Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Massachusetts** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Intensive Supports Waiver

C. Waiver Number:MA.0827

D. Amendment Number:

E. Proposed Effective Date: *(mm/dd/yy)*

07/01/15

Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Revisions to the performance measures have been made to align with the new sub-assurances and reflect the continued evolution of our quality oversight of this waiver. Appendix H is updated to reflect that reporting for this waiver will be combined with reporting for the Community Living Waiver (MA.0826) and the Adult Supports Waiver (MA.0828).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	Public Input, Contact
☑ **Appendix A – Waiver Administration and Operation**	Quality Improvemen
☑ **Appendix B – Participant Access and Eligibility**	B-5, Quality Improve
☑ **Appendix C – Participant Services**	C-5, Quality Improve
☑ **Appendix D – Participant Centered Service Planning and Delivery**	Quality Improvemen
☐ **Appendix E – Participant Direction of Services**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	G-2, Quality Improv
☑ Appendix H	
☑ Appendix I – Financial Accountability	Quality Improvemen
☐ Appendix J – Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Revisions to the performance measures have been made to align with the new sub-assurances and reflect the continued evolution of our quality oversight of this waiver. Appendix H is updated to reflect that reporting for this waiver will be combined with reporting for the Community Living Waiver (MA.0826) and the Adult Supports Waiver (MA.0828).

Appendix B-5 has been modified to ensure this waiver conforms to section 1924.

Attachment #2 and Appendix C-5 reflect the waiver-specific transition plan for this waiver.

Appendix G-2 has been updated to include information in the new subsection G-2-c on the prohibition on use of seclusion in this waiver.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Massachusetts** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Intensive Supports Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **MA.009.01.01**

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

The purpose of this Waiver is to provide flexible and necessary supports and services to adults 22 years and older eligible for services through the Department of Developmental Services who meet the ICF-ID level of care and are determined through an assessment process to require supervision and support 24 hours, 7 days per week to avoid institutionalization. Based on the severity of their functional impairments these individuals require a comprehensive level of support over 24 hours. These individuals may reside in out–of-home settings or in their family home with a comprehensive array of supports.

Individuals in this waiver have a high level of support needs due to significant behavioral, medical, and/or physical support needs. Individuals have access to all state plan services. Individuals in this waiver need 24/7 support either in an out of home placement or with additional supports and supervision in the family home. For individuals who reside in the family home although natural supports and state plan supports are available, they are insufficient to meet the needs of the individual. The combination and coordination of waiver services, natural supports, Medicaid State Plan services, generic community resources support the individual to continue to live successfully in the family home.

For individuals who can not and do not have family to provide care for them, the waiver services in combination with Medicaid services, and generic community resources make it possible for them to successfully live in the community.

The population to be served in this waiver includes individuals moving from ICF-IDs, individuals transitioning from nursing facilities to the community, young adults aging out of special education and individuals whose needs and caregiver circumstances have become more complex, requiring additional in home supports and supervision or placement outside of the family home. The individuals in this waiver present with a substantial risk for out of home placement due to their extraordinary needs. The intensive supports waiver has no prospective individual budget limit.

Goal:

The goal of this waiver is to provide support to these individuals in their communities to prevent the need for restrictive institutional care.

Organizational Structure:

The Department of Developmental Services (the Department), the state agency within the Executive Office of Health and Human Services responsible for providing supports to adults with intellectual disabilities, is the lead agency tasked with the day-to-day operation of this waiver. The Executive Office of Health and Human Services, the single State Medicaid Agency, through the Office of Medicaid, oversees the Department's operation of the waiver. The Department is organized into four geographical Regional Offices with 23 Area Offices assigned to the regions. Intake and Eligibility into the system occurs at the regional level through a dedicated group of Waiver Eligibility Teams. These teams collect information and conduct assessments to determine if the individual meets the agency's eligibility criteria. If determined eligible, individuals are assigned to the Area Office nearest the city or town where they live. The Area Office builds on the information and assessments collected during the eligibility process to determine prioritization for services, service needs and funding level.

Service Delivery:

DDS operates as an Organized Health Care Delivery system, directly providing some of the services available through this waiver and contracting with other qualified providers for the provision of other services. Services may be participant-directed, or purchased through either a Fiscal Management Service or through an Agency with Choice Model. Support brokerage is available to participants. Services may also be delivered through the traditional provider based system. Individuals may choose both the model of service delivery and the provider. The Department of Developmental Services

makes payments to providers through the Meditech claims processing system. DDS's payments are validated through the state's approved MMIS system through which units of service, approved rates and member eligibility are processed and verified.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Department has done extensive briefings and sought input with its major stakeholder representatives including the following: Statewide Advisory Group (SAC), Developmental Disabilities Council, Federation for Children with Special Needs, Down Syndrome Congress, Mass Families Organizing for Change, DDS Family Support Council, Advocates for Autism of Massachusetts (AFAM), Association of Developmental Disability Providers (ADDP), MASS (the self-advocacy organization), and The ARC.

PowerPoint materials have been developed and shared and made available for sharing with other members of the stakeholder membership. The Department has also consulted with other Executive Branch agencies and its oversight agency.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Bernstein

First Name:

Amy

Title:

Director, Community Based Waivers

Agency: MassHealth

Address: One Ashburton Place

Address 2: 11th floor

City: Boston

State: **Massachusetts**

Zip: 02108

Phone: (617) 573-1751 **Ext:** ☐ **TTY**

Fax: (617) 573-1894

E-mail: Amy.Bernstein@state.ma.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: George

First Name: Janet

Title: Assistant Commissioner of Policy, Planning, and Children's Services

Agency: Department of Developmental Services

Address: 500 Harrison Avenue

Address 2:

City: Boston

State: **Massachusetts**

Zip: 02128

Phone: (617) 624-7766 **Ext:** ☐ **TTY**

Fax:

(617) 624-7578

E-mail:

Janet.George@state.ma.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Tsai

First Name:

Daniel

Title:

Assistant Secretary and Director of MassHealth

Agency:

Executive Office of Health and Human Services

Address:

One Ashburton Place

Address 2:

11th Floor

City:

Boston

State: **Massachusetts**

Zip:

02108

Phone:

(617) 573-1600 **Ext:** ☐ **TTY**

Fax:

(617) 573-1894

E-mail:

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Transition Plan:
The minimum age for waiver participants has been raised to 22 years or older. There are currently four individuals under the age of 22 enrolled in the current Residential Waiver. Three of the four participants currently under that age of 22 will be turning 22 before the end of June 2013 and will continue to be enrolled in the Intensive Supports Waiver as of July 1, 2013. The fourth participant will turn 22 in September 2013. All services will continue to be provided to this individual, however no claims for FFP will be submitted for services prior to his 22nd birthday.

Individuals who are authorized to receive Behavior Modification interventions classified as Level III interventions (as defined in 115 CMR 5.14) are not enrolled in the waiver. Additionally, individuals receiving services in provider settings in which the provider is authorized to provide and/or perform Level III interventions are not enrolled in the waiver.

There are a small number of individuals who will be transitioning into the Intensive Supports Waiver from either the Adult Supports or Community Living Waiver. These participants will receive a fact sheet describing the waiver services prior to the implementation and will be provided information on how the waiver participant can contact a DDS staff person if he or she has questions. Information about the Waivers will be posted on the agency website. The service coordinators, Area and Regional directors as well as staff in the waiver unit will be available to answer questions. Participants will be made aware to notify the service coordinator if they believe that their needs have changed. Current participants based on their assessed needs and the Plan of Care will either remain in their current waiver or transitioned to one of the renewal waivers.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency (MassHealth), convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based settings at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the Intensive Supports, Adult Supports, and the

Community Living waivers, participated in the workgroup. All regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified.

Participants in the Intensive Supports Waiver live in 24-hour residential settings, including settings that are private/provider owned or leased, state operated settings and placement services. Participants receiving Placement services may live either in their own homes or apartments, or in the home or apartment of the Placement Services caregiver. Homes or apartments owned or rented by waiver participants are considered to fully comply with the HCBS Regulations.

Further review and assessment of the settings in which the following waiver services are provided is currently underway: Community Based Day Supports, Group Supported Employment and Individual Supported Employment.

Additional details regarding the process used to review HCBS Settings types and whether they comply with the HCBS Regulations may be found in the revised Statewide Transition Plan submitted informally to CMS on February 25, 2016. After CMS review, this revised Statewide Transition Plan will be put forth for public input and formally submitted to CMS.

As indicated in Appendix C-5, concurrent with the systemic review of regulations, policies and procedures and provider qualification processes related to residential settings, the state embarked on a review, in conjunction with its providers, to assess whether 24-hour residential settings are in compliance with the Community Rule. This review included development of a review tool that borrowed extensively from the CMS exploratory questions and review of settings by DDS Central Office, Regional and Area Office staff to categorize settings as meets, not yet (but could with minor changes), not yet (but could with substantive changes) and no (cannot meet).

Based upon the DDS review and assessment, all the 24-hour residential settings serving participants in the Intensive Supports, Adult Supports, and Community Living waivers were determined to be either be in compliance with federal HCB settings requirements (1,012 placement services), not yet be in compliance with federal HCB settings requirements because of the requirement to have locks on all individual participant's bedroom doors, and legally enforceable leases (2,183 private or state operated settings), and not yet in compliance with federal HCB settings requirements because of the need for more substantial changes (14 private or state providers, representing 57 sites).

The 24-hour residential setting provider qualifications are reviewed through the DDS licensure and certification process on an on-going basis. All waiver providers are subject to ongoing review on the schedule outlined in Appendix C of the waiver application.

Concurrent with the systemic review of regulations, policies and procedures and provider qualification processes, DDS developed a voluntary survey that was distributed to Community-Based Day Support (CBDS) providers. The tool was instrumental in evaluating the current state of CBDS settings statewide with respect to the Community Rule requirements by asking providers about their progress in Community Rule compliance. It provided valuable information to inform DDS's approach to enhancing CBDS services through capacity building, technical assistance, training and fiscal support.

Survey data indicates that a wide variety of activities are offered by most CBDS settings; that activities are offered both on-site and off-site; that many activities are most commonly offered in a group; and that offered activities are disability-specific as well as integrated into the community. The survey results indicated that CBDS settings were challenged systemically to meet the Community Rule in several ways, including but not limited to: insufficient funding to enable individualization, access and integration; staff ratios that are not sufficient to facilitate individualized activities; individuals from different populations with varying needs; lack of access to public transportation and unclear standards/definitions/criteria.
Based upon the review and assessment, the non-residential settings mentioned above fall into the following designations
• The non-residential setting complies: 300 (these represent group and individual employment settings)
• The non-residential setting, with minor or more substantive changes, will comply: 170 (these represent CBDS settings)
• The non-residential setting cannot meet the requirements: none

A DDS/provider workgroup has been formed and is meeting regularly to address systemic changes that are needed in order to bring all CBDS services into compliance with the Community Rule. Such changes, given the survey data, may include, without limitation, reforms in provider certification requirements and/or processes, enhanced training and staff development activities, standards for meaningful community integration in the context of CBDS programs, provider technical assistance to enhance program design and operation, and contract-based incentives related to outcome goals in the Community Rule. Findings will be validated through ongoing Licensure and Certification processes. All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.
The state anticipates development of clear guidelines and standards that define day services, including what constitutes meaningful day activities, and how services and supports can be integrated into the community more fully. Technical

assistance, training and staff development will be provided to assist providers in complying with the HCBS Regulations.

Individuals receiving services in settings that cannot meet requirements will be notified by the state agency providing case management. The case manager will review with the participant the services available and the list of qualified and fully compliant providers, and will assist the participant in choosing the services and providers, from such list, that best meet the participant's needs and goals.

For all settings in which changes will be required, DDS has instituted an on-going compliance review process to assure that the changes are monitored and occur timely and appropriately. This process will include consultation and support to providers to enable them to successfully transition, quarterly reporting by providers to update DDS on progress towards compliance, and reviews by designated Area, Regional and Central Office DDS staff to assure adherence to transition plans and processes. All settings in which waiver services are delivered will be fully compliant with the HCBS Regulations no later than March 16, 2019.

Massachusetts outreached to the public to solicit input on this Intensive Supports Waiver amendment through multiple formats. The waiver was posted to MassHealth's website and newspaper public notices were issued in the Boston Globe (DATE), Worcester Telegram and Gazette (DATE), and the Springfield Republican (DATE). In addition, emails were sent on (DATE) to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP-RS amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. The waiver amendment was also discussed in the quarterly conference call with tribal representatives held on (DATE).

Massachusetts also engaged in an extensive process to obtain public review and input of its HCBS Transition Plan. The state provided opportunities for public comment as follows:

1. During two 30-day public comment periods:
• October 15 through November 15, 2014 – on the statewide transition plan; and
• May 18, 2015 through June 18, 2015 – on the addendum to the statewide transition plan regarding non-residential waiver services.

2. At three public forums:
• Statewide Transition Plan (STP): November 6, 2014 (Wellesley, MA); November 12, 2014 (Westfield, MA)
• Non-residential Services Addendum: June 1, 2015 (Worcester, MA)

The public forums were advertised on October 15, 2014 (for the STP) and on May 18, 2015 (for the addendum) in three newspapers each: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. The advertisements in each newspaper directed individuals to the EOHHS website. Information in this link as of October 15, 2014 included a summary of the new federal rule, the draft statewide transition plan, links to the draft DDS, MRC and EOEA agency-specific transition plans, and provided the mailing address and e-mail address for submission of public responses, comments and input to the transition plan. Similarly, materials accessible through this link as of May 18, 2015 included the draft addendum to the statewide transition plan, links to the DDS, MRC and EOEA agency-specific transition plan addenda addressing non-residential service settings, a mailing address and an e-mail address to which public responses, comments and input to the transition plan addendum could be sent.
For both the draft STP and the draft addendum, EOHHS also emailed links to the draft documents as well as information on the public comment periods to several hundred people, including key advocacy organizations and the Native American tribal contacts. The transition plan and the addendum were also discussed during quarterly conference calls with the tribal representatives on October 21, 2014 and July 20, 2015, respectively. Pursuant to CMS's instruction, the newspaper notice, email, and website all provided details for requesting a printed copy of the Non-Residential Services Addendum, and copies of the Non-Residential Services Addenda were made available at the public forum.

In addition, DDS engaged stakeholders in a series of meetings and outreach activities:
• Initial introduction of the intent of the HCBS rule and the process DDS was going to use with DDS staff, providers, advocacy groups, individuals and families;
• Ten regional meetings (April – June 2014) with providers and DDS staff to provide more details;
• Formation of a stakeholder group to review and provide input into the draft transition plan. This stakeholder group included representation from several advocacy groups including but not limited to Arc/Massachusetts, Massachusetts Advocates Standing Strong, Disability Law Center, Massachusetts Families Organizing for Change, Massachusetts Developmental Disabilities Council, the Brain Injury Association of Massachusetts, and the Association of Developmental Disability Providers; and

- Information and updates on the DDS website

Prior to submission of its final transition plan to CMS, EOHHS will post the final transition plan, information originally contained in the addendum addressing non-residential service settings as well as revisions based on the previous receipt of public comments, for an additional public notice and comment period.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Department of Developmental Services; While DDS is organized under EOHHS and subject to its oversight authority, it is a separate agency established by and subject to its own enabling legislation.
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver

operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
EOHHS Office of Medicaid (OOM) and DDS will enter into an Interagency Service Agreement which outlines the responsibilities of the parties. DDS performs all case management functions, is responsible for the needs assessment process, service plan development and service authorization activities and contracting with and reimbursing waiver service providers, respectively. DDS will ensure that contractors adhere to the contractual obligations imposed on them, will work with the contractors regarding their performance of waiver functions and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment. b) DDS will enter into an Interagency Service Agreement with OOM to document the responsibility for performing and reporting on these functions. c) OOM will meet routinely with DDS staff regarding the performance of these activities as well as collect and report data and other information collected from DDS to CMS.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
For those individuals who participate in participant-direction, Financial Management Services are furnished as an administrative activity between the Department of Developmental Services and its Fiscal Management Service, Public Partnerships Limited (PPL) as a result of a Request for Proposals. The agreement between PPL and DDS provides for a monthly Financial Management Services fee per individual served.

PPL reports budget status to the Department of Developmental Services and to participants on a monthly basis. PPL executes individual contracts with each waiver participant for Financial Management Services and with the participant and the provider of direct services and supports.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DDS is responsible for assessing the performance of the contracted entities.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Department of Developmental Services is responsible under its competitive procurement and negotiated contract to manage the performance of the FMS. The Department has established performance metrics and requires the FMS to meet them and has established a process of remediation if they do not achieve them. These benchmarks and required reports are reviewed in a face-to -face quarterly meeting. Between the quarterly meetings there is regular contact with the Fiscal Management Service to address any issues that might arise. Assessment is ongoing. The FMS maintains monthly individual budgets on a management information system and provides monthly financial reports to both the participants and the Department. Monthly invoices contain specific line items identifying the disbursements made on behalf of participants. Monthly FMS reports reconcile expenditures for a participant with that participant's approved budget. Quarterly reports by the FMS analyze expenditures by 1) types of goods and services purchased, 2) similar categories of supports and service plans and reconciliation reports. There are also reports that analyze accuracy and timeliness of payments to providers and accurate and timely invoicing for goods. Reports examine the monthly spending and track this against the participant's allocation. The Fiscal Management Service executes Provider Agreements on behalf of the Department and only does so for individuals engaged in participant-direction. The FMS maintains a good-to-provide list which it regularly scans and updates for changes in provider qualifications. DDS also reviews the provider list regularly and alerts the FMS to changes needed in it. The FMS is also required to maintain a complaint log and share it and the resolution of complaints with DDS. DDS also regularly solicits input about quality of the FMS from participants and DDS staff. The Department includes participants using the FMS in the National Core Indicator Consumer sample. For additional descriptions please refer to Appendix E.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid

Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
AA 1. OOM, DDS and the Financial Management Service Agency (FMS) work collaboratively to ensure systematic and continuous data collection and analysis of the FMS entity functions and systems, as evidenced by the timely and appropriate submission of required data reports. Numerator: The number of FMS reports

submitted to DDS on time and in the correct format. Denominator: Number of FMS reports due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Financial Management Service Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Specify:

Performance Measure:
AA 2. OOM/DDS work collaboratively to improve quality of services, by, in part, ensuring that service provider oversight is conducted in accordance with policies and procedures. Numerator: Number of service provider reviews conducted in accordance with waiver policies and procedures. Denominator: Total number of service provider reviews due during the period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Enhancement Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA 3. Percent of individuals who have an annual LOC re-assessment. Numerator: Number of individuals who have an LOC re-assessment within 12 months of their initial assessment or of their last re-assessment. Denominator: Number of individuals enrolled in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMRIS Consumer Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
AA 4. Participants are supported by competent and qualified case managers. Numerator: Number of case manager evaluations completed as required. Denominator: Number of case managers due for performance evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance Evaluations

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. As problems are discovered with the management of the waiver program processess at waiver service providers or DDS Area Offices, DDS and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, the Office of Medicaid is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☑	**Intellectual Disability**	22		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			
		Serious Emotional Disturbance			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐				

b. Additional Criteria. The State further specifies its target group(s) as follows:

Individuals age 22 and older with intellectual disability as defined by DDS who meet the ICF-ID level of care and are determined through an assessment process to require supervision and support for 24 hours, 7 days per week to avoid institutionalization. Based on the severity of their functional, behavioral, and/or medical impairments these individuals require an intensive level of support over 24 hours; their needs for supervision and support cannot be met by the services that are contained in the Adult Supports Waiver or the Community Living Waiver. These individual may reside in out of home settings or in their family home with a robust array of supports. Individuals who are authorized to receive Behavior Modification interventions classified as Level III interventions (as defined in 115 CMR 5.14) are not enrolled in the waiver. Additionally, individuals receiving services in provider settings in which the provider is authorized to provide and/or perform Level III interventions are not enrolled in the waiver. An individual cannot be enrolled in, or receive services from more than one Home and Community Based Services (HCBS) waiver at a time.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ◉ **Not applicable. There is no maximum age limit**
- ○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ○ **A level higher than 100% of the institutional average.**

  Specify the percentage:

- ○ **Other**

  Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an

amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	8797
Year 2	8970
Year 3	9118
Year 4	9218
Year 5	9218

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Nursing Home Transitioning to Community	
Emergencies and Changing Needs	
Priority Status	
Turning 22 Students - Transitioning from Special Education	
Intermediate Care Facility for the Intellectually Disabled	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Nursing Home Transitioning to Community

Purpose *(describe):*

The state reserves capacity for individuals who require waiver supports as determined through an assessment process. Individuals placed from a skilled nursing facility to the community. As part of the Rolland vs. Patrick Settlement Agreement, the Department has agreed to transition individuals from Nursing Homes into the community. The state will set aside capacity for these individuals who are a priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.

Describe how the amount of reserved capacity was determined:

The capacity was determined based on a legislative appropriation for nursing home population and is tied to a Settlement Agreement.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	120
Year 2	120
Year 3	120
Year 4	

Waiver Year	Capacity Reserved
	100
Year 5	100

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Emergencies and Changing Needs

Purpose *(describe):*

The state reserves capacity for individuals who require waiver supports as determined through an assessment process. Specifically, individuals in emergency situations and those with changing needs. The state will set aside capacity for these individuals who are a priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.

Describe how the amount of reserved capacity was determined:

The reserved capacity is based on the Department's experience of managing emergencies and changing needs.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	100
Year 2	110
Year 3	90
Year 4	90
Year 5	90

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Priority Status

Purpose *(describe):*

The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specifically individuals who are a Priority 1 for Community 24-hour Residential Supports as defined in 115 CMR 6.0. First Priority means the provision, purchase, or arrangement of supports available through the Department is necessary to protect the health or safety of the individual or others. For individuals who are Priority 1, the Department through its planning process with individuals attempts to secure services within 90 days or less from the date of the prioritization letter.

The state will set aside capacity for these individuals who are a priority for enrollment.

All participants enrolled in the waiver will have comparable access to all services offered in the waiver.

Describe how the amount of reserved capacity was determined:

The reserved capacity is based on the Department's experience of providing services to its Priority 1 individuals.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	192
Year 2	130
Year 3	100
Year 4	60
Year 5	60

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Turning 22 Students - Transitioning from Special Education

Purpose *(describe):*

The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specifically, transitioning students from Special Education who are assessed as a high priority for needing Community 24-hour Residential Supports.

The state will set aside capacity for these individuals who are priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.

Describe how the amount of reserved capacity was determined:

The reserved capacity is based on a legislative appropriation for the T-22 class. The Department has historical information and an assessment and prioritization system which informs the Department about the number of T-22 students who will need the level of service of this waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	210
Year 2	200
Year 3	200
Year 4	200
Year 5	200

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Intermediate Care Facility for the Intellectually Disabled

Purpose *(describe):*

The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specifically transitioning individuals from ICF-ID facilities to the community. All participants in the waiver will have comparable access to all services offered in this waiver..

Describe how the amount of reserved capacity was determined:

The Department has a plan to close four of its facilities over the course of the next four years and the capacity was determined based on a thorough analysis of previous closures and Departmental experience.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	30
Year 2	42
Year 3	13
Year 4	12
Year 5	12

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

When an application for waiver enrollment is made to the Central Waiver Unit, the Waiver Unit confirms that the individual meets the basic requirements for Medicaid eligibility and the level of care for the waiver. The Waiver unit confirms that the Choice form has been signed as well. The Central Office Waiver unit maintains a statewide date-stamped log, organized by the DDS regions, of completed waiver applications. Based on the administration of the MASSCAP the individual is prioritized for services and a determination is made as to which waiver's target group criteria the individual meets. Participants prioritized for services must also be assessed as needing the service within 30 days. The Department requires that all adult individuals seeking waiver services apply for and maintain Medicaid eligibility. The Central Office Waiver Unit confirms that there is available capacity in the waiver and that the individual's needs for health and safety can be met. Based on the individual's priority status an offer of enrollment is made. Those individuals who can not be enrolled because of lack of capacity will be placed on a waiting list until

such time as capacity becomes available. When new resources are allocated by the Legislature for specific target groups there will be reserved capacity set aside for them. Individuals in emergency situations who meet the criteria for enrollment are not subject to the process outlined above. If assigned waiver resources are available an individual is expected to enroll in the waiver. The State will utilize the total slots estimated in the application.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (•) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

- (●) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage: [ ]
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount: [ ]
- ( ) **A percentage of the Federal poverty level**

  Specify percentage: [ ]
- ( ) **Other standard included under the State Plan**

  Specify:

  [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]
- ( ) **Other**

  Specify:

  [ ]

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The amount is determined using the following formula:**

  Specify:

  [ ]

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

◉ **Other**

Specify:

300% of the SSI Federal Benefit Rate (FBR)

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The State does not establish reasonable limits.**
○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services must be scheduled on at least a monthly basis. Monitoring on at least a monthly basis will occur under circumstances in which the individual does not receive scheduled services for longer than a one month period.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Information necessary for making the initial evaluation of level of care (LOC) for waiver applicants is collected by the State's Regional Intake and Waiver Eligibility Teams (see B-6-d). Each team includes state waiver eligibility specialists and licensed doctoral level psychologists who supervise the eligibility team members' administration of the level of care for the waiver applicant. Team members include state social worker(s), state eligibility specialists, and access to a nurse. Their qualifications are as follows:

Psychologist IV
Applicants must have at least three years of full-time, or equivalent part-time, professional experience as a Licensed Psychologist in the application of psychological principles and techniques in a recognized agency providing psychological services or treatment, of which (B) at least one year must have included supervision over Post-doctoral Psychologists-in-training and/or Psychological Assistants.

Clinical Social Worker
Required work experience: At least two years of full-time or equivalent part-time, professional experience as a clinical social worker after earning a Master's degree in social work.
Substitutions:
- A Doctorate in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for the required experience on the basis of two years of education for one year of experience.
- One year of education equals 30 semester hours. Education toward a degree will be prorated on the basis of the proportion of the requirements actually completed.
Required education: A Master's or higher degree in social work is required.

Licenses:
- Licensure as a Licensed Certified Social Worker by the Massachusetts Board of Registration in Social Work is required

State Eligibility Specialists
State Service Coordinators; State Eligibility Specialists
Applicants must have at least three years of full-time or equivalent part-time, professional experience in human services; of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities;) or any equivalent combination of the required experience and the substitution below.

Substitutions:
1. A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience.*
2. A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience.
3. Applicants who meet all federal requirements for Qualified Mental Retardation Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
*Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

Service Coordinators
Applicants must have at least (A) three years of full-time or equivalent part-time, professional experience in human services; (B) of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities; deafness; blindness; multi-handicapped) or (C) any equivalent combination of the required experience and the substitution below.

Substitutions:
1. A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience.*
2. A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience.
3. Applicants who meet all federal requirements for Qualified Mental Retardation Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
*Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Vineland II (or another valid and reliable measure of adaptive functioning as determined by a DDS licensed Psychologist, such as the Adaptive Behavior Assessment Scale may be substituted), is administered at the time of eligibility to determine the functional impairments of the individual. The initial evaluation of level of care is based on the MASSCAP process which consists of an assessment of the individual's need for supervision and support and an assessment of the specialized characteristics of the individual and the capacity of the caregiver to provide care. The Individual Client and Agency Planning (ICAP), the Consumer and Caregiver Assessment (CCA) in conjunction with the Vineland II constitute the MASSCAP process. The ICAP is an automated, standardized and validated tool that assesses an individual's adaptive functioning. The domains assessed by the ICAP include motor skills, social and communication skills, personal living skills and community living skills. The ICAP also assesses maladaptive behavior. Other reliable information that is evaluated in making this determination includes, but is not limited to, psychological or behavior assessments, additional functional and adaptive assessments, educational, health, mobility, safety and risk assessments. The CCA process further amplifies the specialized needs of the individual and assesses the caregiver's capacity to provide care. For individuals who remain at home an additional Family Support Allocation Process assessment is performed. This assessment is designed to more fully articulate the caregiver's strengths and needs to provide care in the home for the waiver participant. Factors such as the age, health status, mental acuity, ability of the caregiver to drive and the potential impact of these factors on the waiver participant are reviewed.

Annually, as part of the care planning process, a reevaluation of level of care is done using the Department's tool which is a shortened version of the MASSCAP. The MASSCAP and all other available assessments are considered if there is a question about whether the individual continues to meet the level of care for the waiver. If at any time during the year the individual has experienced significant changes in their life, the MASSCAP will be administered to determine if there is a changing need which warrants a change in level of care or services.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Regional Eligibility Teams (RET) across the state conduct the initial evaluations of all new applicants for the Department's services. This team is comprised of a doctoral level licensed psychologist, a social worker, eligibility specialists, a team manager, and consultation from a registered nurse as necessary. The eligibility process includes administration of the MASSCAP. The Service Coordinator participates in the initial evaluation process as part of the team.

Subsequent to the initial level of care determination, level of care is reevaluated annually by the individual's Service Coordinator at each of the individual's annual supports planning meetings. This reevaluation is conducted using a shortened version of the MASSCAP. If there is a question as to whether the individual continues to meet the level of care, the full MASSCAP is administered. The re-evaluation process would be identical to original evaluation process if at any time during the year, it is determined that the individual has changing needs or circumstances that might impact their level of care, the entire MASSCAP is administered. The Service Coordinator would also be part of that evaluation team/process.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The state ensures timely reevaluations of level of care through the use of its automated information system. The system tracks an individual's level of care score and also the date the next reevaluation is due. Through the use of management reports each Area Director is provided with the data needed to ensure the timely completion of the reevaluations. Reports of overdue LOCS are reviewed for correction within 30 days.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Determinations of level of care are maintained in electronic records as part of the DMRIS Management Information System. Paper records are maintained for each waiver participant at the departmental Area Office in accordance with 115 CMR 4.0.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC a1. Percent of applicants who received an initial LOC assessment within 90 days of waiver application. (Number of individuals who received an initial LOC assessment within 90 days of waiver application/Number of individual who received an initial LOC assessment.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
DMRIS Consumer Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC c1. Percent of initial level of care assessments completed that were applied appropriately and according to the DDS policies and procedures. (Number of exception reports completed by licensed pyschologists of level of care instruments that are returned for cause/Total number of initial level of care assessments administered).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Exception report generated by psychologists

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Performance Measures LOC a1

DDS Regional Office Intake and Eligibility Teams maintain and continuously update the Intake and Eligibility Database, which is part of the DMRIS consumer database. The database logs the initial application date, and the effective date of the eligibility determination. Eligibility determinations cannot be made unless a level of care assessment (ICAP) has been completed. Staff of the Regional Eligibilty Teams and DDS Central Office Waiver Unit will review the data to make sure that all individuals who have applied for DDS services have received an initial LOC assessment within 90 days. A report will be generated to display the number of days it took to complete an eligibility determination. Since each region has its own intake and eligibility team, the data is analyzed by region to determine if there are any patterns and trends with respect to performance.

Performance Measure LOC c1.

At the time of the initial eligibility determination, the Regional Office Intake and Eligibility Team administers the ICAP to determine the level of care of the applicant. Licensed psychologists review all documentation that was submitted as part of the process to determine whether the Intake and Eligibility Team has applied all information appropriately and arrived at the correct conclusion with respect to individual determinations. Any part of the process completed incorrectly by the team is returned for correction.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Performance Measures LOC a1.
Issues identified in the Intake and Eligibility database are referred back by the Waiver Unit to each Regional Intake and Eligibility Team for follow up and correction. The DDS Regional Director is responsible for ensuring that all issues are corrected and the Waiver Unit reviews the database on an ongoing basis to ensure that timelines have been met.

Performance Measure LOC c1.
If the licensed psychologist disagrees with the conclusions, the LOC is returned to the Regional Office Intake and Eligibility Team with comments, review and corrections. A report will be generated by each psychologist reviewer indicating the number of determinations returned for further review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As part of the eligibility process the eligibility team begins the process of determining whether the individual meets the financial and clinical eligibility criteria for waiver enrollment. The Team also conducts the MASSCAP to assess whether the individual meets the ICF-ID LOC requirement for entrance into the Waiver. Based on both the individual's MASSCAP eligibility status and the level of care, the Intake and Eligibility Specialist will supply the individual and family/guardian with information regarding the waiver. This will include giving the individual an oral explanation along with a printed brochure regarding waiver services. The individual or legally responsible person will be provided the Choice form/application, and their rights as it pertains to service delivery options with their eligibility letter. The signature on the choice form/application documents their selection of waiver services by signing the Choice form. This document is submitted to the Department for review and determination of compliance with the first level of criteria for waiver enrollment: choice of community services as a feasible alternative to institutional services. The appropriate Area Office receives notice from the Waiver Management Unit about the status of the waiver application.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A copy of the "Waiver Choice Assurance Form" is maintained by the Targeted Case Manager in the legal section of the individual's record for a minimum of three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Department has developed multiple approaches to promote and help ensure access to the waiver for Limited English Proficient persons. One of the central methods is a contractual relationship established between the Department and the Multicultural Services Translation Center in order to provide written information to families and individuals with Limited English Proficiency in their primary language. This includes information such as applications, brochures, forms that need to be signed by individuals and family members/guardians, service plans, etc. General Waiver and service information needed by families is typically translated into six languages, other than English, which are most commonly spoken by residents in Massachusetts. This includes Spanish, Portuguese, Chinese, Russian, Vietnamese, and Khmer. The Translation Center has a roster of translators and interpreters for other languages as well so that we can respond to the need of families who speak languages beyond those listed previously, such as Haitian Creole or French. In addition to providing translated information, interpreters are made available when needed to enable individuals and family members to fully participate in planning meetings. These interpreters can be made available through the Multicultural Services Translation Center or through other local providers under state contract.

Another important method the Department utilizes to promote access to Waiver services is by working to build capacity among service providers to become more culturally responsive in their delivery of services. One central effort involves building in contractual requirements stipulating that providers must be responsive to the specific ethnic, cultural, and linguistic needs of families in the geographic area they serve. It is expected that this is addressed in multiple ways including outreach efforts, hiring of bi-lingual and bi-cultural staff, providing information in the primary languages of the individuals and families receiving services, and developing working relationships with other multi-cultural community organizations in their communities. Another approach involves working collaboratively with minority community organizations that provide an array of social services to help in outreach to identify individuals and families who may be eligible for services from the Department and through the Waiver, as well as to build their capacity to provide waiver services. This is especially relevant in certain communities in which the presence of a "trusted member" from that particular ethnic and linguistic community is critical for individuals and families to be open to accepting disability related support services, such as in the Vietnamese, Cambodian, and Haitian communities.

The Department is committed to continue to develop and enhance efforts to provide meaningful access to services by individuals with Limited English Proficiency.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Center Based Day Supports		
Statutory Service	Group Supported Employment		
Statutory Service	Individualized Home Supports		
Statutory Service	Live-In Caregiver		
Statutory Service	Residential Habilitation		
Statutory Service	Respite		
Extended State Plan Service	Day Habilitation Supplement		
Other Service	24-Hour Self Directed Home Sharing Support		
Other Service	Adult Companion		
Other Service	Assistive Technology		
Other Service	Behavioral Supports and Consultation		
Other Service	Chore		
Other Service	Community Based Day Supports		
Other Service	Family Training		
Other Service	Home Modifications and Adaptations		
Other Service	Individual Goods and Services		
Other Service	Individual Supported Employment		
Other Service	Individualized Day Supports		
Other Service	Occupational Therapy		
Other Service	Peer Support		
Other Service	Physical Therapy		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Speech Therapy		
Other Service	Stabilization		
Other Service	Transitional Assistance Services		
Other Service	Transportation		
Other Service	Vehicle Modification		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Center Based Day Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Center Based Day Supports are services and supports that lead to the acquisition, improvement, and/or retention of skills and abilities to prepare an individual for paid employment in integrated community settings. This service includes prevocational services (formerly called either facility-based or sheltered workshops) provided in center-based settings. Services are not predominantly job-oriented, but are intended to develop and teach general habilitative skills such as increasing an individual' attention span, completing assigned tasks, following directions, learning effective communication skills with supervisors, co-workers, and customers, learning acceptable workplace conduct and dress, developing workplace problem solving skills and strategies, safety and mobility training that are associated with the successful performance of compensated work. The service may include volunteer work that contributes to the development of non job specific skills that promote employability. Individuals receiving pre-vocational services must have employment related goals identified in their Individual Service Plan which are reviewed at least annually. This service may include the identification of specific habilitative skills, the development and implementation of an individualized plan of supports and strategies, education about the benefits or work for individuals and their families, a preference assessment using inventories, observations, situational assessments, volunteer experiences and tours. Participation in pre-vocational services is not required for participation in individual or group supported employment. The service is intended to be time limited.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA (20 U.S.C. 1401 et seq.) Services that are furnished to the individual are prevocational rather than vocational in accordance with 42 CFR ~440.180(c)(2)(i).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non--profit or for-profit Group or Center-Based Day Supports Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Center Based Day Supports

Provider Category:
Agency

Provider Type:
Non--profit or for-profit Group or Center-Based Day Supports Providers

Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey & Certification staff.

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Group Supported Employment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Group Supported employment services consist of the ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need support to perform in a regular work setting. The outcome of the service is sustained paid employment and work experience leading to further career development and individual integrated community employment for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefit paid by the employer for the same or similar work performed by individuals without disabilities. Small group supported employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile work crews, enclaves and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities including co-workers, customers, supervisors. Group supported employment may include any combination of the following services: job-related discovery or assessment, assisting the participants to locate a job or develop a job on behalf of the participants, job analysis, training and systematic instruction, job coaching, negotiation with prospective employers, and benefits support. Typically group supported employment consists of 2-8 individuals, working in the community under the supervision of a provider agency. The individuals are generally considered employees of the provider agency and are paid and receive benefits from that agency. Group supported employment includes activities needed to sustain paid work by participants including supervision and training and may include transportation if not available through another source. . Transportation between the participants' place of residence and the employment site or between the provider site and the group employment site may be provided.

Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program
When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)

Group supported employment does not include volunteer work or vocational services provided in facility based work settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Work/Day Non Profit, For Profit and State Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Group Supported Employment

Provider Category:
Agency
Provider Type:
Work/Day Non Profit, For Profit and State Provider Agencies
Provider Qualifications
License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)
Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.
Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an
emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of
the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan
by the Team.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Habilitation
Alternate Service Title (if any):
Individualized Home Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Individualized Home Supports consists of services and supports in a variety of activities that may be provided regularly but that are less than 24 hours per day that are determined necessary to prevent institutionalization. This service provides the support and supervision necessary for the participant to establish, live in and maintain on an on-going basis a household of their choosing, in a personal home or the family home to meet their habilitative needs. These services assist and support the waiver participant and may include teaching and fostering the acquisition, retention or improvement of skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community as specified in the Plan of Care. It may include training and education in self-determination, self advocacy to enable the participant to acquire skills to exercise control and responsibility over the services and supports they receive to become more independent, integrated and productive in their communities. The service includes elements of community habilitation and personal assistance. This service excludes room and board, or the cost of facility upkeep, and maintenance. This service is not provided to waiver participants living in 24-hour licensed group home settings, placement services, or receiving self-directed 24 hour supports. An assessment is conducted and a Plan of Care is developed based on that assessment. The service is limited to the amount specified in the waiver participant's Plan of Care. This service may be delivered in a one's own home, or a family home, or in the community. The locating of appropriate housing is not covered as part of this service. No individual provision duplicates services provided under Targeted Case Management. This service may not be provided at the same time as Respite, Group or Individual Supported Employment, Center-Based Work Supports, Community Based Day Supports, Individualized Day Supports, Individualized Goods and Services, or Adult Companion or when other services that include care and supervision are provided. This service may be self-directed through either the Fiscal Intermediary or Agency with Choice.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is 23 hours or less per day. This service is not available to participants who receive residential habilitation or receive 24 hour self-directed home sharing supports.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Qualified Individual Providers
Agency	Residential/Work/Day Individual or Family Support Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individualized Home Supports

Provider Category:
Individual
Provider Type:
Qualified Individual Providers
Provider Qualifications
License *(specify):*
Certificate *(specify):*
High School diploma, GED, or relevant equivalencies or competencies.
Other Standard *(specify):*
All individual providers must:
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individualized Home Supports

Provider Category:
Agency
Provider Type:
Residential/Work/Day Individual or Family Support Provider Agency
Provider Qualifications
License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)
Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.
Other Standard *(specify):*

Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of
the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Management - Survey and Certification Staff.

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):
Live-In Caregiver

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
The payment for the additional costs of rent and food that can reasonably be attributed to a live-in personal caregiver who resides in the same household as the waiver participant. Payments for live-in caregiver services are made to the waiver participant. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. The live-in caregiver may provide up to 40 hours per week of direct service including self-directed adult companion, self-directed individualized home support self-directed individual supported employment or individualized day support. The live-in caregiver service must be self-directed, paid through the Fiscal Intermediary. The live-in caregiver may

not be related by blood or marriage to any degree. The live-in caregiver can not be employed by a provider of waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Live-in caregiver can not provide more than 40 hours of direct service per week.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Live-in Caregiver

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Live-In Caregiver

Provider Category:
Individual

Provider Type:
Individual Live-in Caregiver

Provider Qualifications

License *(specify):*

Certificate *(specify):*
High School Diploma, GED, equivalencies, or relevant competencies.

Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be
knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Annually or prior to utilization of service.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential habilitation consists of ongoing services and supports by paid staff that are designed to assist individuals to acquire, maintain, or improve the skills necessary to live in a non-institutional setting. Residential habilitation is available to individuals who need daily staff intervention with care, supervision and skills training in activities of daily living, home management and community integration and live in a certified or licensed home with 24 hour staffing. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports such as safety sign recognition and money management, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision 24 hours a day.

This service may also include the provision of medical and health care services that are integral to meeting the daily needs of the participants. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of residential habilitation services and included in the rate paid to providers of residential habilitation services. Provider owned or leased facilities where residential habilitation services are furnished are compliant with the Americans with Disabilities Act.

The types of residential habilitation are Provider or State Operated Group Residences where residential habilitation is delivered with 24 hour paid staff in a licensed home with other individuals receiving supports and Placement Services where residential habilitation is delivered through a support agency which provides placement, guidance and oversight for individuals with 24 hour paid supports who live in the home of a care provider or live in their own homes with a care provider who lives with them. The care provider is unrelated to the individual and is not an employee of the support agency.

Residential habilitation is not available to individuals who live with their immediate family unless the immediate family member (grandparent, parent, sibling or spouse) is also eligible for the Department's supports.

Payment is not made for the cost of room and board including the cost of building maintenance, upkeep and improvements. The method by which room and board are excluded from payment for residential habilitation is specified in Appendix I. Payment is not made directly or indirectly to members of the individual's immediate family except as provided in Appendix C-2.

Residential habilitation provided in a provider licensed Group Residence cannot be self-directed. Individuals residing in licensed group residences may however, choose to direct other services in this waiver. Individuals can not receive both Residential Habilitation and 24-Hour Self Directed Home Sharing Support or Live-in Caregiver services. Only one residential support is permitted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Residential Habilitation Providers

Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).

Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Services are provided in either: a) licensed respite facility, b) in the home of the participant, c) in the family home, or d) in the home of an individual family provider to waiver participants who are unable to care for themselves. Services are provided on a short-term overnight basis where there is an absence or need for relief of those persons who normally provide care for the participant or due to the needs of the waiver participant. Respite care may be made available to participants who receive other services on the same day, such as Group or Individual Supported Employment, Centered Based Work Supports or adult day-care, however, payment will not be made for respite at the same time when other services that include care and supervision are provided.

Respite may not be provided at the same time as Individualized Goods and Services, when a service rather than a good is being provided.

Facility-based respite cannot be participant-directed. Others forms of respite may be self-directed. The choice of the type of respite is dependent on the waiver participant's living situation.

Federal financial participation will only be claimed for the cost of room and board when provided as part of respite care furnished in a facility licensed by the state.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite may be provided up to 30 days per year and is reflected in the Individual Service Plan based on assessed need.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Respite Provider
Agency	Respite Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Individual Respite Provider
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.
Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Respite Provider Agency
Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*
High School Diploma, GED, or equivalencies or relevant competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service
Service Title:
Day Habilitation Supplement

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Day Habilitation Supplement consists of supplemental services that are provided at free-standing Day Habilitation program sites and is not available to waiver participants in any other program, setting or site. These supplemental services are not otherwise available under the Medicaid State plan, and are services which the Department of Developmental Services has determined are necessary to enable the individual to participate in a day habilitation program. The supplemental services consist of focused one-to-one assistance for individuals who have significant support needs who are either medically fragile with issues such as dysphasia, aspiration, and repositioning and/or exhibit extreme behavioral actions such as serious self-injurious behavior or injurious behavior directed at others such as pica, severe head-banging, pulling out fingernails and toenails, biting and other forms of aggression. The one-to-one assistance insures that the health and safety issues of both the participant and others who participate in the Day Habilitation program are met. Many of the participants have severe intellectual disability and are fully dependent on caregivers for risk management and protection. The scope and nature of these services do not otherwise differ from day habilitation services furnished under the State plan. Transportation between the participant's place of residence and the day habilitation site is not provided as a component of the day habilitation supplement; meals are not provided as a component of the Day Habilitation Supplement. The provider qualifications specified in the State plan apply. This service cannot be self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to 5 days per week and no more than 6 hours per day based on assessed need of the waiver participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	MassHealth Certified Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Day Habilitation Supplement

Provider Category:
Agency
Provider Type:
MassHealth Certified Providers
Provider Qualifications
License *(specify):*
130 CMR 419.401 (MassHealth Day Habilitation Center Services Regulations).
Certificate *(specify):*
Committee for Accreditation of Rehabilitation Facilities (CARF).
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Committee for Accreditation of Rehabilitation Facilities (CARF).
Frequency of Verification:
One to three years depending on level of certification.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
24-Hour Self Directed Home Sharing Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
24-Hour Self-Directed Home Sharing Support consists of ongoing services and supports by paid care giver(s) that is designed to assist individuals to acquire, maintain, or improve the skills necessary to live in a non-institutional setting. The service is available to individuals who need daily staff intervention with care, supervision and skills training in activities of daily living, home management and community integration and live in a home of their own or live in the home of a care provider identified by the waiver participant or the legally responsible individual. . The care provider is identified and supervised directly by the waiver participant or the legally responsible individual. Unlike Placement Services in Residential Habilitation, there is no support agency involved in the 24-Hour Self-Directed Home Sharing Support. Like placement services there is an assessment to determine the intensity of the need of the individual in relation to the daily payment rate for the care provider. There are three levels of intensity in the model. 24-Hour Self-Directed Home Sharing Support means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, recognition and money management, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. 24-Hour Self-Directed Home Sharing Support also includes personal care and protective oversight and supervision 24 hours a day.

This service may also include the provision of medical and health care services that are integral to meeting the

daily needs of the participants or arranging and assisting individuals to access the health care system. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of 24-Hour Self-Directed Home Sharing Support and is included in the individual's participant budget. 24-Hour Self-Directed Home Sharing Support must be purchased through a self-directed budget. This service may not be provided at the same time as Respite, Individualized Home Supports, or Adult Companion or when other services that include care and supervision are provided

24-Hour Self-Directed Home Sharing Support services are not available to individuals who live with their parent or spouse unless that individual is also eligible for the Department's supports. Family members who are either the legal guardian or legal representative or spouse can not provide 24-Hour Self-Directed Home Sharing Support. Other family members such as siblings or cousins, aunts, uncles may provide these services. These services may be arranged and organized by a family member or legally responsible individual. Payment is not made for the cost of room and board including the cost of building maintenance, upkeep and improvements. The method by which room and board are excluded from payment for residential habilitation is specified in Appendix I. Payment is not made directly or indirectly to members of the individual's immediate family except as provided in Appendix C-2. 24-Hour Self-Directed Home Sharing Support can not be provided in a provider licensed Group Residence or staffed by a provider agency. The physical site is either owned or leased directly by the waiver participant or the direct care provider and not by the provider agency. 24-Hour Self-Directed Home Sharing Support services can only be self-directed through an individual budget and paid through a fiscal management service. 24-Hour Self-Directed Home Sharing Support is limited to one individual in the same site. Licensed providers may not act as the employer of the care provider and may not provide services in one of their licensed settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Qualified Self-Directed 24 Hour Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: 24-Hour Self Directed Home Sharing Support

Provider Category:
Individual

Provider Type:
Individual Qualified Self-Directed 24 Hour Support Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*

Possess appropriate qualifications as evidenced by interviews, two personal or professional references and a CORI, Age 18 years or older, be knowledgeable about what to do in an emergency, be knowledgeable about
how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, must maintain confidentiality and privacy of consumer information, must be respectful and accept different values, nationalities, races, religions, cultures, and standards of living, specific competencies needed by an individual provider to meet support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Services

Frequency of Verification:

Annually or prior to utilization of service.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Non-medical care, supervision and socialization provided to an adult. Services may include assistance with meals and basic activities of daily living such as shopping, laundry, meal preparation, routine household care incidental to the support and supervision of the individual. The service is provided to carry out personal outcomes identified in the individual plan that support the individual to successfully reside in his/her home or in the family home. Adult companion may also be provided when the caregiver regularly responsible for these

activities is temporarily absent or unable to manage the home and care. Adult companion services are also available for an individual in his/her own residence who requires assistance with general household tasks.

This service does not entail hands on nursing care. Provision of services is limited to the person's own home, family home, or in the community. This service may not be provided at the same time as Chore, Individualized Home Support, Respite, Group or Individual Supported Employment, Individualized Day Supports, Center Based Day Supports, Community Based Day or when other services that include care and supervision are provided. This service may be self-directed through either the Fiscal Intermediary or through Agency with Choice.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is 23 hours or less per day. This service is not available to participants who receive residential habilitation including those who reside in 24 hour licensed group settings or placement settings or who receive 24 hour self-directed home sharing supports. It is only available to individuals who live in their family home or in a home of their own.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Individual Provider
Agency	Residential/Work/Day Individual or Family Support Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Individual

Provider Type:
Qualified Individual Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
High School diploma, GED, or relevant equivalencies or competencies.

Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion

Provider Category:
Agency
Provider Type:
Residential/Work/Day Individual or Family Support Provider
Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification Staff.
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Assistive technology is defined as an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, including the design and fabrication that is used to develop, increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, rental, or customization or use of an assistive technology device. This service also covers maintenance, repairs of devices and rental of assistive technology during periods of repair. Assistive technology includes – the evaluation of the assistive technology needs of the participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for participants; services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants. Assistive Technology must be authorized by the Service Coordinator as part of the Individual Service Plan. The Service Coordinator will explore with the individual/legal guardian the use of the Medicaid State Plan. Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the individual's disability.

Assistive technology must be purchased through a self-directed budget through the Fiscal Intermediary.

Adaptive Aids must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements where applicable for design, safety, and utility.

There must be documentation that the item purchased is appropriate to the participant's needs.

Any Assistive Technology item that is available through the State Plan must be purchased through the State Plan; only items not covered by the State Plan may be purchased through the Waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Contractors authorized to sell this equipment or make adaptations
Individual	Individual Qualified contractors authorized to sell this equipment or make adaptations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Qualified Contractors authorized to sell this equipment or make adaptations
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Qualified contractors authorized to sell this equipment or make adaptations and that meet state requirements to sell, maintain or modify equipment. Qualified contractors providing assistive technology and or assistive technology services for persons with intellectual disabilities that are covered by Medicare or Medicaid, or Qualified contractors qualified by Medicare/Medicaid as a multi-specialty clinic providing assistive technology services. They must hold a valid tax payer ID number.
Payment for services is made only to providers who meet the following requirements:

To qualify as an Assistive Technology provider, all applicants and providers must:
(1) agree to accept assignment of rates developed by the Division of Health Care Finance and Policy (DHCFP) for all products and services provided;
(2) have a primary business telephone number listed in the name of the business;
(3) primarily engage in the business of providing Assistive Technology services, or medical supplies to the public;
(4) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive technology business practice;
(5) for a private provider of seating, positioning, and mobility systems, employ an assistive technology practitioner or habilitation technology specialist (RTS) who is registered with the National Registry of Rehabilitation Technology Suppliers (NRRTS), and be an active member of the Rehabilitation Engineering Society of North America (RESNA);
(6) conduct CORI checks on all employees or subcontractors where the employee or subcontractor delivers or sets up equipment in the member's home.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:
Individual
Provider Type:
Individual Qualified contractors authorized to sell this equipment or make adaptations
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Contractors must meet state requirements to sell, maintain or modify equipment. They must hold a valid tax payer ID number.

Payment for services is made only to providers who meet the following requirements:
To qualify as an Assistive Technology provider, all applicants and providers must:

(1) agree to accept assignment of rates developed by the Division of Health Care Finance and Policy (DHCFP) for all products and services provided;
(2) primarily engage in the business of providing Assistive Technology, assistive tech repair services, or medical supplies to the public;
(3) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive technology business practice;
(4) for a provider of seating, positioning, and mobility systems, employ a rehabilitation technology specialist (RTS) who is registered with the National Registry of Rehabilitation Technology Suppliers (NRRTS), and be an active member of the Rehabilitation Engineering Society of North America (RESNA);
(5) conduct CORI checks on all employees or subcontractors where the employee or subcontractor delivers or sets up equipment in the member's home.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavioral Supports and Consultation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Behavioral supports and consultative services are clinical and therapeutic services and that are necessary to improve the individual's independence and integration in their home or in their community. This service is available to waiver participants and is designed to remediate identified challenging behaviors or to acquire socially appropriate behaviors. Behavioral supports and consultation are provided by professionals in the fields of psychology, mental health, or special education. The service may include a a) functional assessment by a trained clinician, b) the development of a positive behavior support plan which includes the teaching of new skills for increasing new adaptive replacement behaviors, decreasing challenging behavior(s) in the individual's natural environments, c) intervention strategies, d) implementation of the positive behavior support plan and associated documentation and data analysis, and e) monitoring of the effectiveness of the plan. Monitoring of the plan will occur at least monthly or more frequently as needed. The service will include any change to the positive behavior support plan when necessary and the professional(s) shall be available to provide recommendations to the ISP team and the Targeted Case Manager including making referral recommendations to community physicians and other clinical professionals that support the assessment findings. In order to carry out supports to Waiver Participants, training, consultation and technical assistance to paid and unpaid caregivers may be provided to enable them to understand and implement the positive behavioral plan at home. This service does not provide direct services to either paid or unpaid caregivers. The behavioral supports and consultation must be consistent with the DDS regulations. Access to this service is only permissible by prior authorization through the Area Office Psychologist or the Area Director. This service is available in the waiver participant's home or in the community. Behavioral Supports and Consultation does not include any service covered by the Medicaid State Plan including individual, group, or family counseling or under private insurance including benefits under ARICA. If the waiver participant has a co-occurring mental health diagnosis those services must be accessed through the Medicaid State Plan. Providers must first access behavioral supports and consultation through their own agency. This service may be self-directed through the Fiscal Intermediary.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-profit or for-profit, state operated Behavioral Support Agencies
Individual	Individual Qualified Behavioral Health Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Supports and Consultation

Provider Category:
Agency

Provider Type:
Non-profit or for-profit, state operated Behavioral Support Agencies

Provider Qualifications

License *(specify):*
If the agency employs individuals to provide behavioral support and consultation, staff must meet all relevant state and federal licensure requirements in their discipline. Doctoral degrees in psychology, education, medicine, or related discipline, any related state licensure required for the discipline.

Certificate *(specify):*
For mental health professionals, such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.

Other Standard *(specify):*
1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disability. The relevant training may be part of an advanced degree program.

Two years of relevant experience in assuming the lead role in designing and implementing behavioral supports and consultation

Individuals with less than the highest advance degree for the discipline can offer the service under the supervision of a licensed individual per state requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Supports and Consultation

Provider Category:
Individual

Provider Type:
Individual Qualified Behavioral Health Provider

Provider Qualifications

License *(specify):*
Doctoral degree in psychology, education, medicine or related discipline, and any state licensure required for the discipline.

Certificate *(specify):*
For mental health professionals, such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.

Other Standard *(specify):*
1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disability. The relevant training may be part of an advanced degree program. Two years of relevant experience in assuming the lead role in designing and

implementing behavioral supports and consultation. Criminal Offense Record Inquiry (CORI) if working directly with the waiver participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Chore

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes minor home repairs, general housekeeping and heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy furniture in order to provide safe egress and access. These services are only provided when neither the participant nor anyone else in the household is capable of performing or financially providing for them and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of the service. Service is not available in a provider operated setting. This service is not available to participants receiving 24-hour self directed home sharing support. Chore service must be paid through a self-directed budget through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Providers
Individual	Individual Qualified Chore Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
Chore Providers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Taxpayer identification number required, 18 years or older, must have a Criminal Offense Record Inquiry (CORI), have two personal or professional references, Must maintain confidentiality and privacy of consumer information, must be respectful and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:
Individual
Provider Type:
Individual Qualified Chore Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Taxpayer identification number required, 18 years or older, must have a Criminal Offense Record Inquiry (CORI), have two personal or professional references, Must maintain confidentiality and privacy of consumer information, must be respectful and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Community Based Day Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope):*
This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of (community) activities in a community setting by providing opportunities for developing, enhancing, and

maintaining competency in personal, social and community activities. The service may include career exploration, including assessment of interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; development and support of activities of daily living and independent living skills, socialization experiences and enhancement of interpersonal skills and pursuit of personal interests and hobbies. The service is intended for individuals of working age who may be on a pathway to employment, a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for individuals who are of retirement age. Community based day supports provides a structured and supervised program of services and supports in a group setting which promotes socialization and peer interaction and development of habilitative skills and achieve habilitative goals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-profit or for profit Center Based Day Support Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Based Day Supports

Provider Category:
Agency

Provider Type:
Non-profit or for profit Center Based Day Support Providers

Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living.
Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Office of Quality Enhancement, Survey and Certification Staff
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Family Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Family Training is designed to provide training and instruction about the treatment regimes, behavior plans, the use of specialized equipment that supports the individual waiver participant to participate in the community. Family Training may also include training in family leadership, support of self-advocacy, and independence for their family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home when the waiver participant visits the family home. Documentation in the individual's record demonstrates the benefit to the individual. For the purposes of this service "family" is defined as the persons who live with or provide care to a waiver participant and may include a parent or other relative. Family Training may be provided in small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of their family member. The one to one family training is instructional; it is not counseling. Family does not include individuals who are employed to care for the individual. Family Training is not available in state-operated or provider-operated residential habilitation sites unless the waiver participant regularly visits the family home. This service may be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Individual Family Training Provider
Agency	Family Training Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Individual
Provider Type:
Qualified Individual Family Training Provider
Provider Qualifications

License *(specify):*
Individuals who meet all relevant state and federal licensure or certification requirements for their discipline.

Certificate *(specify):*
Relevant competencies and experiences in Family Training.

Other Standard *(specify):*
Applicants must possess appropriate qualifications to serve as staff as evidenced by interviews, two personal or professional references, and a Criminal Offense Record Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advoacy, and skills in training in independence.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency
Provider Type:
Family Training Agencies
Provider Qualifications

License *(specify):*
Agency needs to employ individuals who meet all relevant state and federal licensure of certification requirements in their discipline.
Certificate *(specify):*
If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary certification requirements for those disciplines must be met.
Other Standard *(specify):*
Agency needs to employ individuals who must be able to effectively communicate in the language and communication style of the individual or family for whom they are providing the training. They must have experience in promoting independence and in family leadership.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Modifications and Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Those physical adaptations to the private residence of the participant, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home. Service includes the assessment and evaluation of home safety modifications. This service can only be provided in the individual's primary residence. Such adaptations include

but are not limited to:
• Installation of ramps and grab-bars
• Widening of doorways/hallways
• Modifications of bathroom facilities
• Lifts: porch or stair lifts
• Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and
supplies, and which are necessary for the welfare of the individual
• Installation of specialized flooring to improve mobility and sanitation
• Specialized accessibility/safety adaptations/additions
• Automatic door openers/door bells
• Voice activated, light activated, motion activated and electronic devices
• Door and window alarm and lock systems
• Air filtering devices and cooling adaptations and devices
• Specialized non-breakable windows
All services shall be provided in accordance with State or Local Building codes.
Excluded are those adaptations or improvements to the home that are of general utility, and which are not of direct medical
or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. General household repairs are not included in this service.
Any use of Waiver funds for home adaptation requests must be submitted and approved in advance following the process outlined below.
The Service Coordinator will explore with the individual and family when relevant, utilization of appropriate modifications that are portable to accommodate changes in residence, size of the individual, and changes in equipment and needs. In addition, all proposals for home adaptations shall plan for the reuse of portable accommodations.
a) Waiver funding shall only be used for renovations that will allow the individual to remain in his/her home (primary residence), and must specifically relate to the functional limitation(s) caused by the individual's disability. It is not available to individuals who visit home periodically but who otherwise reside elsewhere.
b) The following steps to request approval for funding must be followed.
• The Service Coordinator must receive for his/her review and recommendation the following information: a proposal detailing the request for funding, and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a home adaptation must be attached to this information.
• If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
• If a home adaptation request is approved, the individual/family must submit, at a minimum, 3 bids that contain costs and a work agreement, to the Department.
c) All payments for Home Adaptations must be made through the Fiscal Management Service and purchased through a self-directed budget. This service must be an identified need and documented in the service plan. The Home Adaptations must be purchased through a self -directed budget through the Fiscal Intermediary.

Funding for Home Adaptations is not available for use in any state operated or provider residence, or in the home of a home sharing care provider. No permanent adaptations to the structure will be made to property rented or leased by the participant, guardian or legal representative.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Not to exceed $15,000 in a five-year period. Only available to individuals who live in the family home or in a home of their own. Not available to providers of residential supports or 24 hour self-directed home sharing in the care provider's home.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Modification Agencies/Assistive Technology Centers
Individual	Individual Qualified Home Modification Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications and Adaptations

Provider Category:

Agency

Provider Type:

Home Modification Agencies/Assistive Technology Centers

Provider Qualifications

License *(specify):*

Contractors for home modifications must be licensed to do business in the Commonwealth and meet applicable qualifications and be insured.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Services

Frequency of Verification:

Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications and Adaptations

Provider Category:

Individual

Provider Type:

Individual Qualified Home Modification Provider

Provider Qualifications

License *(specify):*

Contractors for home adaptations must be licensed to do business in the Commonwealth and meet applicable qualifications and be insured.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Developmental Services

Frequency of Verification:

Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual Goods and Services are services, equipment or supplies that will provide direct benefit and support specific outcomes that are identified in the individual waiver participant's service plan. The Individual Goods and Services are not provided through either other waiver services or the Medicaid State Plan. The Individual Goods and Services promote community integration, or provide resources to expand opportunities for self-advocacy, or decrease the need for other Medicaid services, or reduce the reliance on paid support, or are directly related to the health and safety of the waiver participant in his/her home or community. Individual Goods and Services are used when the waiver participant does not have the funds to purchase the item or service from any other source.

Examples of allowable Individual Goods and Services include:

Enrollment fees, dues, membership costs associated with the individual's participation in community habilitation, training, supplies, and materials that promote skill development and increased independence for the individual with a disability in accessing and using community resources. The Individual Goods and Services must be purchased through a self-directed budget. This service must be pre-approved by the Team and subject to DDS rules and must be an identified need and documented in the service plan. Experimental and prohibited treatments are excluded. The Individual Goods and Services may not be provided at the same time as respite, or any employment or day activity program. Individual Goods and Services excludes all services and supplies provided under specialized medical equipment and supplies or assistive technology. This service must be self-directed paid through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to $1,500 per waiver year.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Qualified Community Vendor
Agency	Vendor agency meeting industry standards in the community according to the goods, services and supports needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:
Individual
Provider Type:
Individual Qualified Community Vendor
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Services, supports, or goods can be purchased from typical vendors in the community. Vendors must meet industry standards in the community.
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:
Agency
Provider Type:
Vendor agency meeting industry standards in the community according to the goods, services and supports needed

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Services, supports, or goods can be purchased from typical vendors in the community. Vendors must meet industry standards in the community.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Individual Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Individual supported employment services consist of ongoing supports that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disabilities, need support to perform in a regular work setting. Individual supported employment may include assisting the participants to locate a job or develop a job on behalf of the participant. Individual supported employment is conducted in a variety of settings, particularly typical work sites where persons without disabilities are employed. Emphasis is on work in an integrated environment with the opportunity for individuals to have contact with co-workers, customers, supervisors and others without

disabilities. In individual supported employment the individual has a job based on his/her identified needs and interests, located in a community business. It may also include self-employment or a small business, or a home-based self-employment, or temporary services which may assist an individual in securing an individual position within a business Individual supported employment may include job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching in the form or regular or periodic assistance; training and support are provided for the purpose of developing, maintaining and/or improving job skills and fostering career advancement opportunities. Job coaching at the job site is not designed to provide continuous on-going support;it is expected that as the individual develops more skill and independence the level of support will decrease and fade over time as the natural supports in the work place are established. Some on-going intermittent job related support may be provided to assist the waiver participant to successfully maintain his/her employment situation. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting. Individuals are paid by the employer. It may include transportation if not available through another source. Transportation assistance between the participants' place of residence and the employment site is included in the rate paid to providers of individual supported employment services. Ongoing transportation for an individual participant is excluded from the rate. Time-limited transportation for components of discovery, career exploration, job development is provided. Once the individual is hired, transportation ceases. Individual supported employment may be self-directed and paid through the Fiscal Intermediary.

Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)

Individual supported employment excludes individuals working in mobile crews or in small groups. It excludes volunteer work.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Qualified Supported Employment Provider
Agency	Work/Day Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Supported Employment

Provider Category:
Individual

Provider Type:
Individual Qualified Supported Employment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
High School Diploma, GED, or relevant equivalencies or competencies.

Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Supported Employment

Provider Category:
Agency

Provider Type:
Work/Day Provider Agencies

Provider Qualifications

License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Individualized Day Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Services and supports provided to individuals tailored to their specific personal goals and outcomes related to the acquisition, improvement, and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, and could not do so without this direct support. This service can only be participant-directed. A qualified family member or relative, independent contractor or service agency may provide services. This service originates from the home of the individual and is generally delivered in the community.
Examples
• Develop and implement an individualized plan for day services and supports;
• Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
• Provide support to explore job interests or retirement options;
• Provide opportunities to participate in community activities, including support to attend and participate in post-secondary or adult education classes;
• Provide support to complete work or business activities including supports for individuals who own their own business;
• Training and support to increase or maintain self-help, socialization, and adaptive skills to participate in own community;

• Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.
This service is not provided in or from a facility-based (center-based or community based) day program. This service is not provided from a provider-operated or state-operated group residence. This service may not be provided at the same time as Group or Individual Supported Employment, Center- based Work Supports, Community Based Day Supports, Individualized Goods and Services Supports or when other services that include care and supervision are provided. This service is only available to waiver participants who self-direct his/her own supports and must be pre-approved by the Team, subject to DDS rules stated above, and must be an identified need and documented in the service plan. The Individualized Day Supports must be purchased through a self-directed budget through either the Fiscal Intermediary or the Agency with Choice.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Qualified Day Support and Services Provider
Agency	Work/Day Support Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Day Supports

Provider Category:
Individual

Provider Type:
Individual Qualified Day Support and Services Provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
High School Diploma, GED, or relevant equivalencies or competencies.

Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated by the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Day Supports

Provider Category:
Agency
Provider Type:
Work/Day Support Provider Agency
Provider Qualifications
License *(specify):*
115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)
Certificate *(specify):*
High School Diploma, GED, or relevant equivalencies or competencies.
Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Occupational Therapy Services, including the performance of a habilitative or maintenance program provided by a licensed Occupational Therapist. Occupational therapy programs are designed to improve the quality of life by recovering competence, preventing further disability or injury and/or to improve the individual's ability to perform tasks of daily living required for independent functioning and to ameliorate sensory issues.. The practice of Occupational Therapy encompasses evaluation, treatment, and consultation. Occupational Therapy services promote/maintain fine motor skills and coordination. Services are habiltiative and are designed to maintain or prevent the worsening of functioning. Occupational therapy services include but are not limited to specifically designed activities and exercises to teach daily living skills and to develop independent skills to enhance the areas of neurodevelopment, cognition, perceptual motor, sensory integrative and psychomotor functioning. OT may also design or apply selective orthotic or prosthetic devices or selected adaptive equipment and assist in the design of adapting environments. Services may also include the training and oversight necessary for the participant, family member or another person to carry out the maintenance program. Occupational Therapy under the waiver is different from State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the State plan. Services are delivered in both offices and in the natural environments of the participant. The service may be provided individually and in small groups, in the natural milieu of the individual or in the community. The provider qualifications specified in the State Plan apply. Occupational Therapy services must be authorized by the Service Coordinator as part of the ISP Team process. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.414 or the requirements for Prior Authorization found at 130 CMR 432.417. The Occupational Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted. Any devices used in the provision of the service must be FDA approved. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service cannot occur in Day Habilitation or in other sites where therapy is being provided. No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment for the same date of service as a comprehensive evaluation. Occupational therapy must be purchased through a self-directed budget through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is subject to the service limitations included in 130 CMR 432.414 (A) and (B). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of services as a comprehensive evaluation.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Care Agency

Provider Category	Provider Type Title
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Health Care Agency
Provider Qualifications
License *(specify):*
The agency must be licensed as a Group Practice in accordance with 130 CMR 423.404 or hold a Clinic License. Services must be performed by an Occupational Therapist licensed in accordance with 130 CMR 432.00.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
Licensed in accordance with 130 CMR 432.00.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Serivces
Frequency of Verification:

Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Peer support is designed to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer support is designed to promote and assist the waiver participant's ability to participate in self-advocacy through either a peer mentor or through an individual/agency peer support facilitator. Peer support may be provided in 1) small groups or 2) peer support may involve one individual who is either a peer or an individual peer support facilitator providing support to a waiver participant. The one to one peer support is instructional; it is not counseling. The service enhances the skills of the individual to function in the community and/or family home. Documentation in the individual's record demonstrates the benefit to the individual. This service may be provided in small groups or as a one-to-one support for the individual. Peer support is available to individuals who reside in 24 licensed settings, in the family home, a home of their own or receive less than 24 hours of support per day. This service may be self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Peer Support Trainers
Agency	Peer Support Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Individual

Provider Type:
Individual Peer Support Trainers

Provider Qualifications

License *(specify):*
Individuals who meet all relevant state and federal licensure or certification requirements for their discipline if needed.

Certificate *(specify):*
Relevant competencies and experiences in Peer Support.

Other Standard *(specify):*
Applicants must possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references and a Criminal Offense Records Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advocacy and skills training and independence.

Minimum of 18 years of age;

Be knowledgeable about what to do in an emergency;

Be knowledgeable about how to report abuse and neglect;

Must maintain confidentiality and privacy of consumer information;

Must be respectful and accept different values, nationalities, races, religions, cultures and standards of living;

Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Agency
Provider Type:
Peer Support Agencies
Provider Qualifications

License *(specify):*
If Agency is providing activities where licensure is necessary, individuals need to meet all relevant state and federal licensure or certification requirements in their discipline.

Certificate *(specify):*
If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary certification requirements for those disciplines must be met.

Other Standard *(specify):*
Agency needs to employ individuals who are self-advocates and supporters must be able to communicate effectively in the language and communication style of the individual or family for whom they are providing training. The applicant must have experience in providing peer support, self-advocacy, skills and training in independence.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Physical Therapy services, including the performance of a habilitative or maintenance program, provided by a licensed Physical Therapist. Services must be considered necessary by DDS for the participant to habilitate, maintain or prevent the worsening of functioning. Services are directed toward the management of movement dysfunction and/or the enhancement of physical and functional abilities. Physical Therapy Services promote/maintain gross/fine motor skills and facilitate independent functioning. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Physical Therapy under the waiver is different from State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the State plan. The provider qualifications specified in the State Plan apply. Physical Therapy services must be authorized by the Service Coordinator as part of the Individual Service Plan. The Physical Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted. Any devices used in the provision of the service must be FDA approved. Services are delivered in both offices and in the natural environments of the participant. The service may be provided individually and in small groups. This service is not subject to the Medical Referral Requirement found at 130 CMR 432.415 or the requirements for Prior Authorization found at 130 CMR 432.417. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service cannot occur in Day Habilitation or in other sites where the therapy is being provided. No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a therapy in which there is no DDS assessment or authorization. Payment will not be made for a treatment for the same date of service as a comprehensive evaluation. Physical Therapy must be purchased through a participant-directed budget through the Fiscal Intermediary.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is subject to the service limitations included in 130 CMR 432.414(A) and (B). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Health Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
Licensed in accordance with 130 CMR 432.00.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Health Care Agency
Provider Qualifications
License *(specify):*
The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 or hold a Clinic license. Services must be performed by a Physical Therapist licensed in accordance with 130 CMR 432.00.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. Accessing the state plan benefits must occur before accessing this service. All items shall meet applicable standards of manufacture, design and installation. The medical support devices or equipment must have proven evidenced-based support and conform with acceptable medical practice; no experimental or alternative devises or equipment are permitted to be purchased. Any devices used in the provision of the service must be FDA approved. Specialized Medical Equipment and Supplies must be authorized by the Service Coordinator as part of the Individual Service Plan process. Specialized medical equipment and supplies must be purchased through a self-directed budget through the Fiscal Intermediary.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to $3,500 per waiver year.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Equipment Providers
Agency	Pharmacies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Specialized Medical Equipment Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following
- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.
- Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Pharmacies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment
process and as such, has successfully demonstrated, at a minimum, the following:
- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.
- Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services
Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Speech Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Speech Therapy services, including the performance of a habilitative or maintenance program provided by a licensed Speech Therapist. Services are habiltiative and are designed to maintain or prevent the worsening of functioning. in the areas of communication and ability to eat, drink, swallow and manage aspiration risks. Speech-language pathology refers to the application of principles, methods and procedures related to the development of disorders that impede oral, pharyngeal, or laryngeal competencies and the normal process of human communication including but not limited to disorders of speech, articulation, fluency, voice, and the

application of augmentative communication treatments. Services may also address swallowing dysfunction. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Speech Therapy under the waiver is different from State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the State plan. Service may be delivered in both offices and in the natural environments of the participant. The service may be provided individually or in small groups. The provider qualifications in the State Plan apply. Speech Therapy services are authorized by the Service Coordinator as part of the ISP Team process.. The Speech Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted. Any devices used in the provision of the service must be FDA approved. The service can only be provided by licensed personnel. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.414 or the requirements for Prior Authorization found at 130 CMR 432.417. This service will not duplicate any services available through the Medicaid State Plan or private health insurance. This service can not occur in Day Habilitation or in other sites where therapy is being provided. No more than one individual treatment and one group therapy session per day may be authorized.. Payment will not be made for a treatment for the same date of service as a comprehensive evaluation. Speech Therapy must be purchased through a self-directed budget through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is subject to the service limitations included in 130 CMR 432.414 (A) and (B). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of services as a comprehensive evaluation.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Health Care Agency
Individual	Speech Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Health Care Agency

Provider Qualifications

License *(specify):*

Licensed as a Group Practice in accordance with 130 CMR 413.404. Services must be performed by a Speech/Language Therapist licensed in accordance with 130 CMR 432.00.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:
Individual

Provider Type:
Speech Therapist

Provider Qualifications

License *(specify):*
Licensed as a Speech Therapist in accordance with 130 CMR 432.00.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Stabilization

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
This service is designed to provide stabilization and support for waiver participants who due to either behavioral or environmental circumstances can not remain in their current residence or family home. The service is provided in either a licensed respite facility or in the home of an individual family provider to waiver participants who are unable to care for themselves. The home of an individual family provider is overseen by a qualified stabilization agency.Based on the waiver participant's assessed needs for stabilization and support and the need to develop a new Individual Plan of Care which will meet the participant's needs, there is no time limit imposed on the service. The service includes over-night supervision and support. Stabilization services may be available to participants who receive other waiver services on the same day, such as community based day supports, center based day supports, group or individual supported employment or individualized day supports or day habilitation supplement. Stabilization services can not be provided when other services that provide care and supervision are being provided. The length of stay is based on the assessed needs of the waiver participant and is regularly reviewed by the Regional Management Team. This service cannot be self-directed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non profit or for-profit residential, individual support stabilization agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Stabilization

Provider Category:
Agency
Provider Type:
Non profit or for-profit residential, individual support stabilization agencies

Provider Qualifications

License *(specify):*

115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)

Certificate *(specify):*

High School diploma, GED or relevant equivalencies or competencies.

Other Standard *(specify):*

Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:

Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transitional Assistance Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence whether or not the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy and; (e) activities to assess need, arrange for and procure needed resources. Transitional Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. This service may be self-directed paid through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Room and board costs are excluded.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individual, Family Support and Residential Provider Agencies
Individual	Individual Qualified Transitional Assistance Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Assistance Services

Provider Category:
Agency
Provider Type:
Individual, Family Support and Residential Provider Agencies
Provider Qualifications

License *(specify):*
115 CMR 7.00, 8.00.
Certificate *(specify):*
High School diploma, GED or relevant equivalencies or competencies.
Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDS Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Assistance Services

Provider Category:
Individual

Provider Type:
Individual Qualified Transitional Assistance Provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
High School Diploma, GED, or equivalencies or relevant competencies.

Other Standard *(specify):*
Possess appropriate qualifications as evidenced by interviews, two personal or professional references and a CORI, Age 18 years or older, be knowledgeable about what to do in an emergency, be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, must maintain confidentiality and privacy of consumer information, must be respectful and accept different values, nationalities, races, religions, cultures, and standards of living, specific competencies needed by an individual provider to meet support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service includes travel to and from day programs and travel for accessing community activities and resources. Transportation may also include the purchase of transit and bus passes for public transportation systems and mileage reimbursement for qualified drivers. The provision of transportation is based on a service plan that meets the need in the most cost-effective manner. Transportation that is part of a day or residential program or a contracted transportation provider cannot be self-directed. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan defined at 42 CFR 440.170(a), and does not replace them.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Individual Transportation Provider
Agency	Transportation Pass Provider
Agency	Not for profit or for profit Transportation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Qualified Individual Transportation Provider

Provider Qualifications

License *(specify):*
Valid Massachusetts Driver's License.

Certificate *(specify):*
High School Diploma, GED, or relevant equivalencies or competencies.

Other Standard *(specify):*
All individual providers must: Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Valid driver's license, liability insurance, RMV inspection; seat belts; Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Annually or prior to utilization of service.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:
Transportation Pass Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Transportation passes may be purchased from vendors or retail locations authorized to sell passes for public transportation systems, bus services or other transit providers. Vendors must meet industry standards in the community.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Annually or prior to utilization of service.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:
Not for profit or for profit Transportation Agency
Provider Qualifications
License *(specify):*
Valid Massachusetts Driver's License.
Certificate *(specify):*

Other Standard *(specify):*
Specifications written into all contracts with transportation providers; attachment to contract which requires valid driver's license, liability insurance, reporting of abuse; timeliness, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication.

Verification of Provider Qualifications
Entity Responsible for Verification:
DDS Regional Transportation Coordinator.
Frequency of Verification:
Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Vehicle Modification

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Vehicle Adaptations
Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.
Examples of vehicle adaptations include:
•Van lift
•Tie downs
•Ramp
•Specialized seating equipment
•Seating/safety restraint
The following are specifically excluded vehicle modifications:
1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.
2. Purchase or lease of a vehicle
3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations.
The individual must be in the family home, vehicle modification is not available to individuals who reside in a provider residential setting or in 24 self-directed 24 home sharing supports or in the live-in caregiver model .
Funding for adaptations to a new van or vehicle purchased/leased by family can be made available at the time of purchase/lease to accommodate the special needs of the participant.
This service is must be an identified need and documented in the service plan. The Vehicle modifications must be purchased through a participant-directed budget and paid through the Fiscal Intermediary
1. The Service Coordinator must receive in advance for his/her review and recommendation the following information: a proposal detailing the request for funding and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a vehicle adaptation must be attached to this information.
2. If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
3. All payments for Vehicle Adaptations must be made through the Fiscal Management Service and purchased through a self -directed budget.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cost not to exceed $15,000 over a five year period. Available to individuals who live in family home. This service is not available to individuals receiving residential habilitation or 24-hour self directed home sharing support or using the live-in caregiver model. The live-in caregiver's vehicle is not eligible for vehicle adaptations, adaptations of the caregiver's private property violates state law. Vehicles owned by residential habilitation providers are not eligible for vehicle modification.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modification Agencies
Individual	Independent Contractors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:
Agency

Provider Type:
Vehicle Modification Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Vehicle Modifications must be performed by certified entities who are licensed to perform vehicle conversions and modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:
Individual

Provider Type:
Independent Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Vehicle Modifications must be performed by certified entities who are licensed to perform vehicle conversions and modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Developmental Services

Frequency of Verification:
Every two years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Department of Developmental Services

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

DDS and its providers are governed by Executive Office of Health and Human Services (EOHHS) regulations 101 CMR 15.01 et seq. For any applicant for a position that has the potential for unsupervised contact with a waiver participant, a CORI (Criminal Offender Record Information) check is performed. These checks are mandated by the regulations. These are checks on the criminal record history in Massachusetts of applicants. No individual may begin to provide services and supports to a waiver participant in an unsupervised setting until a CORI check is completed. Providers submit the CORI request to the Department of Criminal Justice Information Services (DCJIS), which is an agency of the Executive Office of Public Safety and Security. The DCJIS sends the results back to the requesting provider agency. The Investigations Division of DDS employs a staff person whose sole responsibility is to conduct audits of provider agencies to assure that all hired employees have undergone a CORI check. Agencies not in 100% compliance with this requirement must submit a corrective action plan. DDS follows up to ensure that the correction action has been completed.

Participants who are self-directing their supports must request a CORI Check through the Financial Management Service (FMS). The FMS Manual contains guidance and the forms to assist the individual in making this request. The FMS receives the CORI report and informs the Department of whether the results prohibit the applicant from being hired.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ◉ **No. The State does not conduct abuse registry screening.**

○ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Respite Facility	
Provider or State-Operated Group Residence	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All community residential settings, regardless of the number of individuals who are served, are subject to the same requirements concerning maintaining a homelike environment. These facilities are located in neighborhoods in cities and towns throughout Massachusetts and are typically existing housing stock but could also be new construction. These homes and the programs within them reflect the normal rhythms of a household with kitchens for preparing meals, dining areas, living rooms and dens, and private and semi-private bedrooms. The existence of a homelike environment and opportunities to access the community are a major review component of the survey and certification process. (See Appendix H)

Current DDS regulations in Chapter 7.00 (Standards for Services and Supports) set an upper limit of 4 individuals in one home. The regulations also provide for waiving this capacity and allowing a capacity of up to 5 individuals. The capacity of 5 is consistent with both State and National Building Code categories, which define a home of 5 or fewer as a residential use. This enables homes developed by DDS to blend into other comparable homes in cities and towns in the State and maintain their residential nature.
The protocol for approving these exceptions includes ensuring that residential group homes are structured as individual's homes. There are also homes that exceed the limit of four that were grandfathered prior to the regulation change. These homes are reviewed against the same environmental and program standards as other residences. These are group homes where individuals have lived together a long period of time and by choice elect to remain in that group home. Subject to the exception protocol and based on their assessed need for specialty supports there are also some newer homes for individuals transitioning from nursing homes which may have 5 participants instead of 4. More than 90% of group residences have no more than four people.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Respite Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech Therapy	☐
Respite	☑
Residential Habilitation	☐
Peer Support	☐
Individualized Day Supports	☐
Family Training	☐
Individual Goods and Services	☐
24-Hour Self Directed Home Sharing Support	☐
Transportation	☐
Occupational Therapy	☐
Community Based Day Supports	☐
Center Based Day Supports	☐
Specialized Medical Equipment and Supplies	☐
Group Supported Employment	☐
Vehicle Modification	☐
Individualized Home Supports	☐
Assistive Technology	☐
Adult Companion	☐
Behavioral Supports and Consultation	☐
Home Modifications and Adaptations	☐
Transitional Assistance Services	☐
Day Habilitation Supplement	☐
Physical Therapy	☐
Stabilization	☑
Individual Supported Employment	☐
Chore	☐
Live-In Caregiver	☐

Facility Capacity Limit:

Four persons (see ii below)

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Provider or State-Operated Group Residence

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Speech Therapy	☐
Respite	☑
Residential Habilitation	☑
Peer Support	☐
Individualized Day Supports	☐
Family Training	☐
Individual Goods and Services	☐
24-Hour Self Directed Home Sharing Support	☐
Transportation	☐
Occupational Therapy	☐
Community Based Day Supports	☐
Center Based Day Supports	☐

Waiver Service	Provided in Facility
Specialized Medical Equipment and Supplies	☐
Group Supported Employment	☐
Vehicle Modification	☐
Individualized Home Supports	☐
Assistive Technology	☐
Adult Companion	☐
Behavioral Supports and Consultation	☐
Home Modifications and Adaptations	☐
Transitional Assistance Services	☐
Day Habilitation Supplement	☐
Physical Therapy	☐
Stabilization	☑
Individual Supported Employment	☐
Chore	☐
Live-In Caregiver	☐

Facility Capacity Limit:

Four persons (see ii below)

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The state makes payments to relatives but not to legal guardians, spouses or legal representatives for furnishing waiver services when the relative is qualified and either the relative is employed by a provider agency or the individual is self-directing his\her services. Relatives employed by qualified provider agencies may provide any waiver service. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications.

When an individual is self-directing his or her services the circumstances under which a relative may be paid are:

• the lack of a qualified provider in the geographic area;
• the lack of a qualified provider who can furnish services at necessary times and places;
• the unique ability of the relative to meet the needs of the participant;
• there is a cost-benefit to having the relative provide the service, such as transportation
• The delivery of services by a relative must be discussed and reviewed during the development of the service plan. This includes why it is more beneficial for the relative to provide the service including any cost-benefit and why it is in the best interest of the participant.

Payment rates to a relative must be consistent with the rates paid by the state for similar supports. Payment is

made only when the service is not a function that a family member normally provides for the individual without charge as a matter of course in the usual relationship among members of a nuclear family. Relatives who would not qualify to be paid caregivers include parents of minor children, spouses or legal guardians. The Targeted Case Manager must review all payments to relatives and ensure that waiver services were delivered. The services included are: individual supported employment, transportation, individualized home supports, individualized day supports, chore, adult companion and respite provided in the home of an individual family provider and 24-hour self directed home sharing support.

Individual providers of home modifications and adaptations and vehicle modifications are not subject to the review process noted above but must meet the individual provider qualifications noted for the relevant service type. Approval of the home or vehicle modification is subject to the service-specific approval process.

Relatives may not be employed as participant-directed providers for the following services: live-in caregiver, behavioral supports and consultation, family training, individual goods and services, assistive technology, occupational therapy, physical therapy, speech therapy, peer support and transitional assistance services.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider has the opportunity to enroll as a provider of waiver services. The Commonwealth's Executive Office of Health and Human Services has a prequalification process (808 CMR 1.04) to determine the fiscal health of the provider. All providers must complete this process in order to qualify as a provider of services.

DDS also has standards that ensure that waiver providers possess the requisite skills and competences to meet the needs of the waiver target population. The Department typically reviews qualifications in 30 days or less and then updates the list of qualified providers. Any participant may choose from among qualified providers who meet both the state's prequalification and DDS service standards.

The Department has posted on its website the requirements and procedures for potential providers to qualify to deliver services. The qualifying system is open and continuous to enable potential providers to qualify as they become ready to deliver services to waiver participants.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP a1. Percent of new providers that received an initial license to provide supports. (Number of new providers that received a license to operate within 6 months of initial review/Number of new providers that were selected to provide supports.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensure and Certification Database Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi- annually

Performance Measure:
QP a2. Percent of licensed clinicians that meet applicable licensure requirements (Number of licensed clinicians with appropriate credentials/Number of licensed clinicians providing services.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS tracking database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Management Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal Management Service	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP a3. Percent of providers that continue to meet applicable licensure or certification standards (Number of providers that continue to meet applicable licensure or certification standards/ Number of providers subject to licensure/certification).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensure and Certification Database Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP a4. Percent of providers that have corrected identified deficiencies (Number of providers that have corrected deficiencies/Number of providers with identified deficiencies.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensure and Certification Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP b1. Percent of individual providers not subject to licensure or certification who are offering self-directed services who meet requirements to provide supports. (Number of individual providers not subject to licensure or certification who meet the qualification requirements to provide services/Number of individual providers providing services.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Fiscal Management Service Tracking Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Management Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: Fiscal Management Service	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP b2. Percent of Support Services Qualified Agency (SSQUAL) Providers that meet the qualifications to provide services. (Number of SSQUAL providers that meet the qualifications to provide services/Number of SSQUAL agency providers providing services)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi- annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi- annually

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP c1. Percent of licensed/certified providers that have staff trained and current in required trainings including medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting. (Number of providers that have staff trained/Number of providers reviewed through survey and certification.)

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
QP c2. Percent of individual providers who have received training in reporting of abuse/neglect and incidents. (Number of individual providers who have received training/Number of individual providers providing services.)

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Fiscal Management Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Fiscal Management Service	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Performance Measure QP a1.
Agency providers that have not previously been licensed or certified for any services by DDS will be subject to "pre-qualification" requirements in order to be listed as a qualified provider. If selected to provide a service subject to licensure and/or certification, the provider will be subject to an abbreviated review according to the existing survey and certification process in order for them to begin to provide services. Within 6 months of initiating services, the provider is subject to a full licensure review.
Performance Measures QP a3., QP a4., and QP c1.

Providers subject to licensure and certification are reviewed by a trained team of surveyors utilizing a tool known as the Quality Enhancement Survey Tool (QUEST). The QUEST tool evaluates providers based upon a set of key domains, including health, safety, protection of rights, staff competency, goal development and accomplishment, choice/control, community membership, and relationships. 100% of providers are subject to on-site reviews. The review is based upon a random sample of individuals served by the provider, representative of the types of services and supports provided. In addition, an organizational review is conducted to assure that the agency is positioned to support quality across all its services and supports. The organizational review includes a thorough review of the agency's quality management systems, its support and oversight of staff (including a review of training records to assure that staff are trained in the required areas) and its methods for continually planning and improving services. Teams of surveyors observe individuals on site, interview individuals, family members and key staff and review documentation on a representative sample of individuals. The results lead to a level of licensure and certification. Depending upon the findings a provider can receive a 2 year license, a 2 year license with a mid-cycle review, a recommendation not to license. A provider can also have its licensure status deferred if it has not met 8 specific critical indicators.
Performance measures QP a2., QP b1, QP c2.
A master list of qualified providers is maintained by the Fiscal Management Service (FMS) for individuals who are self-directing. Individual providers offering services in the future, will be required to submit documentation of their qualifications (according to the standards previously delineated). Support brokers will work directly with individuals to assure that all appropriate documentation and requirements are submitted for review. The support broker will review the material, make sure that the packet is complete and then submit to the Fiscal Management Service for final verification. The Fiscal Management Service will retain copies of all relevant information, conduct the CORI check and place a provider on the "qualified" list upon completion of all necessary paperwork and successful CORI checks. The FMS will be responsible for maintaining a current and accurate Master Provider List.

Performance Measure QP b2.
Providers proposing to offer support services are required to submit documentation of their qualifications to provide the range of services. All submissions are reviewed by a committee of DDS. Providers not submitting complete and accurate information are returned and are not permitted to be included on a qualified provider list.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure QP a1.
Issues identified during the abbreviated review must be corrected and follow up is conducted by survey and certification staff. Issues identified at the full licensure review within 6 months of initiating service are also subject to follow up by survey and certification staff.

Performance Measures QP a3., QP a4., and QP c1.
Survey and Certification teams identify specific provider issues in the provider report generated from routine licensure/certification reviews. Identified issues, specifically those that pose an immediate health and safety risk are subject to immediate follow-up (24-48 hours). Other issues are subject to follow up within 30-60 days. A report is generated specifically indicating areas needing correction and required follow up. Surveyors verify and document that correction has been completed. Providers that fall below a prescribed percentage of compliance on any specific standard are subject to follow up by survey and certification staff as well as on-going monitoring from Area Office Program Monitors. Providers with a two year license with a mid-cycle review cannot take on any new business until all issues are corrected.

Performance Measures QP a2., QP b1., QP c2.
The Fiscal Management Service assures that all necessary documentation to qualify a provider is complete and that a CORI check has been completed prior to placing an individual on the qualified provider list. In the event that documentation is incomplete or demonstrates that the individual may not be qualified, the application is returned and not approved. The Fiscal Management Service also checks request for reimbursement for services rendered against the qualified provider list to assure that only qualified providers are compensated for their services.

Performance Measure QP b2.
Providers not submitting the required documentation are identified and are not permitted to be included on the qualified provider list.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e)

the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☑ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

a) The aggregate number of day and employment supports can not exceed the total number of business days per month as expressed in 8 hours per day. Maximum number of hours varies by month but total can not exceed 184 hours in any month.
b) The limit is based on DDS historical experience providing these supports in its current Residential, Community Living and Adult Supports Waiver.
c) The limit will not be adjusted based on appropriation because there are no more available business days.
d) The limit for day and employment services can not be exceeded to meet the health and safety needs of the waiver participant. Additional supervisory services may be needed to meet the participant's health and welfare needs. If the participant has identified emergency needs the waiver has the mechanism in place to assure health and safety of the participant. Service coordinator maintains regular contact with the providers of waiver services across all settings. Both the Risk Management System and the Critical Incident Reporting System continuously alert the Service Coordinator to possible emergency needs. Residential provider programs are subject to licensure and certification. Waiver participants are also observed by a variety of service providers across a variety of settings. DDS also has available a RN or Nurse Practitioner in the Department's Area Offices to provide medical consultation as well as Psychologists to provide behavioral consultation. Medical and Behavioral issues are the most common types of emergencies in the system. All providers have developed Emergency back-up plans. All families have been advised and instructed to create emergency back-up plans. All providers have back up plans for weather related emergencies and actively participate in COOP planning regionally. All are connected to the Massachusetts Emergency Management Agency. Families are also advised to alert local officials of the presence of an individual with a disability in their home.
If the waiver participant can not be safely served on the waiver the participants will be offered other state plan services to address the participant's health and safety needs.
e)The participants will be offered the right to appeal as described in Appendix F.
f)) The Quality Assurance System as described in Appendix H outlines the safeguards that are in effect to insure continuous monitoring of the participant by the DDS Service Coordinator. The description of services and the amounts of the limits are available on the DDS website. As part of the service planning process the DDS Targeted Case Manager notifies participants of the prospective individual budget limit.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Department employs Service Coordinators who meet the requirements of the State Plan for Targeted Case Management.
Service Coordinators:
Applicants must have at least (A) three years of full-time or equivalent part-time professional experience in human services; (B) of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities; deafness; blindness; multi-handicapped) or (C) any equivalent combination of required experience and the substitution below.

Substitutions:
1. A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience*
2. A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience.
3. Applicants who meet all federal requirements for Qualified Mental Retardation Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
4. *Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

Personnel Qualifications Required at Hire:
Knowledge of the principles and theories of human growth and development.
Knowledge of the principles and techniques of counseling, especially people with disabilities and their families.
Knowledge of the types and symptoms of mental and/or emotional disorder
Knowledge of interviewing techniques and of motivation and reinforcement techniques.
Knowledge of the types of services and supports available to people with disabilities and their families.
Knowledge of group process for counseling.

Knowledge of methods of general report writing.
Ability to understand and explain the laws, rules, regulations, policies, procedure, specifications, standards and guidelines governing agency activities.
Ability to exercise discretion in handling confidential information.
Ability to make comprehensive assessments by examining records and documents and through questioning and observing consumers.
Ability to plan training or instruction and to facilitate groups.
Ability to effectively coordinate the activities of an interdisciplinary team.
Ability to make effective oral presentations and to give oral and/or written instruction.
Ability to evaluate and maintain accurate records.
Ability to interact with people who are under physical or emotional stress and to deal tactfully with others.
Ability to make decisions, act quickly and maintain a calm manner in a stressful and/or emergency situations.
Ability to establish and maintain harmonious working relationships with others.
Ability to respond to multiple demands for consumers and staff.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Service Coordinator supports a participant through the entire service planning, also known as home and community based waiver plan of care development/planning process. The Service Planning Process described in Appendix D produces the Waiver Plan of Care document. This support includes helping the participant prepare for the meeting and assisting them to voice their wants and needs at the meeting.

The Service Coordinator has a discussion with the participant or guardian prior to the service plan meeting. If the participant agrees, other team members such as family and staff may also participate in this discussion. The discussion includes:

• The person's goals and vision for the future
• A review of the past year and the participant's present circumstances
• Issues to discuss or not to discuss at the service plan meeting
• Identification of additional assessments needed for planning
• Explanation of the service plan process to the participant, family and guardian
• Who to invite to the meeting
• The date, time, and place of the meeting

Other preparation includes talking to people who know the participant well such as staff, friends, advocates, and involved family members. In selecting people to talk to, the Service Coordinator respects the participant's wishes about who is part of the service planning process. When participants cannot communicate their preferences, Service Coordinators collect information through observation, inference from behavior, and discussions with people who know the participant well. All conversations should be respectful of the participant and focus on the person's strengths and preferences. The Service Coordinator also looks for creative ways to focus the team on the unique characteristics of the person and his (or her) situation. The Service Coordinator does this by helping team members think creatively about how they can better support the person.

During the service planning consultation, the participant and Service Coordinator identify who will be invited to the meeting. These participants constitute the team members. In situations where personal and sensitive issues are discussed, certain team members may be invited to only part of the meeting. Any issue about attendance at the service planning meeting is resolved by the Service Coordinator.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The state uses a single service planning process that is designed to yield two documents; the Plan of Care (POC) and the Individual Support Plan (ISP). This process occurs annually with a full plan developed once every two years and a plan update in the interim year. The process each year is similar, calling for a review of assessments and progress notes and a meeting of the Team. The general components of the service planning process are located at 115 CMR 6.00.

• Pre-Meeting Activities - supporting the participant to take part in the process (see D-1-c above), notifying participants of the meeting and securing all necessary assessments and progress summaries;
• Creating the Plan – developing vision statements, delineating current supports, noting any significant events that have occurred and recommending any support changes that may be needed, and identifies risks needing to be addressed and developing goals, objectives and strategies for attainment and responsibilities of participants;
• Plan Implementation – semi-annual review of the participant's satisfaction with supports and progress towards meeting goals;
• Plan Update – conducting an annual review and update of the plan; and
• Plan Modification – reconvening the team if a significant change occurs at any time to modify the plan, if necessary.

The Service Coordinator is the principle organizer of the service plan. Other team members include the participant, the guardian, family, and other identified formal and informal supporters. As stated in Section D-1-c, support is provided to the participant to take part in the process and voice their preferences.

The Service Coordinator's responsibilities include developing a service plan with the participant and his/her

guardian, as appropriate, requesting and reviewing assessments, goals, objectives and strategies, facilitating the meeting, ensuring the plan represents the participant's needs, maintaining the electronic service plans, monitoring the participant's satisfaction with the plan and progress on goals and scheduling periodic progress or update meetings.

The Service Coordinator is responsible for any reasonable accommodation needed for the participant's or family/guardian's involvement in service planning. Accommodations may include personal assistance, interpreters, physical accessibility, assistive devices and transportation.

ASSESSMENTS, PROGRESS NOTES AND STATUS REPORTS
Assessments provide information on a participant's goals, capabilities, and need for skill development as well as general progress towards attaining objectives. The required assessments are: the Assessment of Ability, the Safety Assessment, the Health and Dental Assessment and the Funds Management Assessment. In addition to these assessments, a behavioral assessment is required for participants who take behavior-modifying medications or have a positive behavior support plan. The Service Coordinator and team members identify additional assessments at the preplanning, service plan or any time as needed.

Progress Summaries
In addition to assessments, the provider writes a progress summary on any existing goals or objectives. This summary includes:
• The source of the information
• The goal or objective being worked on
• What progress has been made
• What the participant's strengths and resources contributed to the progress
• What strategies worked or didn't work
• Any obstacles to reaching the goal
• Providers are also required to write progress summaries.
Progress summaries are submitted to the service coordinator on at least a semi annual basis or more frequently as determined by the ISP Team members. Based on the individual's progress on the goals, the Service Coordinator will determine whether there is any need for changes to objectives and strategies.

INFORMING THE PARTICIPANT OF SERVICES AVAILABLE UNDER THE WAIVER
Information about waiver services is first provided to potential participants at the time of waiver eligibility. Upon initial enrollment in the waiver, the Service Coordinator will provide the participant with information about supports available under this waiver and potential providers of these supports. The Service Coordinator will also communicate the qualifications and requirements for certain service providers as noted in Appendix C. Information is also available on the DDS website. If waiver participants request additional information, or if their needs change, additional information about waiver services is made available. At the Service Planning meeting, the Service Coordinator provides each participant with a waiver brochure which enumerates the services available in the Waiver program, a brochure describing the Choice of Service Delivery Method, and a Family Handbook which explains the concepts of Choice, Portability and Service Options within the waiver structure. The participant is also provided a current list of all qualified agency providers of services. Participants are encouraged to ask questions and discuss waiver service options as part of the Individual Service Planning process.
ADDRESSING PARTICIPANTS GOALS, NEEDS AND PREFERENCES
The service plan meeting is divided into seven parts: 1)Individual Vision; 2)Current Supports; 3)Safety and Risk; 4) Legal/ Financial/ Benefit Status; 5) Successes, Challenges, Emerging Issues and Unmet Needs; 6) Goals; 7) Objectives and strategies.

Individual Vision
The meeting begins with a discussion of the participant's vision based on four questions discussed with the individual prior to the meeting. The four questions are based on principles of Person Centered Planning aimed at determining the areas the individual identifies as import skill areas to develop.

Current Supports
Team members will describe how they are supporting the participant and how those supports are affecting the person's life. Team members compile a list of supports-formal, informal, paid and unpaid—for the 7 support categories.

Safety and Risk

Team members identify the individual's safety skills and supervision needs. The Team also identifies any issues that pose a risk to the individual or the community. Strategies are identified to address any safety and risk issues.

Legal/ Financial/ Benefit Status
The ISP Team updates documentation of the individual's legal status, the benefits he or she receives and information regarding his or her financial resources. It is intended to support the individual in assuring the individual maintains essential supports, including entitlement income, health insurance, and support needed in decision making.

Successes, Challenges, Emerging Issues, Unmet Support Needs
The service plan meeting provides an opportunity for the ISP Team to highlight specific events and experiences that have has a significant impact on the individual over the 2 year cycle of the ISP or are anticipated to have a significant impact on the individual in the future. Satisfaction with current services and requests for new services are addressed in this section.

Goals
The ISP Team list the Goals to be addresses over the next two years. The Goals reflect what is important to the individual and relate to his or her Vision Statement and/or assessed needs.

Objectives
This section lists the Objectives that will be addressed , based on the Vision Statement and assessed needs and to the greatest extent possible develop skills in order to promote independence and self reliance . Supports include personal and natural supports, assistive technology, and generic and professional services.

ASSIGNING RESPONSIBILITIES
Following the meeting the goals and objectives are carried out by the appropriate Team member identified at the ISP meeting. The providers track, document, and review progress for each goal. The review dates for each goal are decided at the meeting and written in the plan. All goals are reviewed as least semi-annually.

The POC details, regardless of funding source, both waiver and non-waiver services the participant will receive. The Service Coordinator has day to day responsibility for POC coordination.

UPDATING AND MODIFYING THE PLAN
At the mid-point between meetings, the team members send progress summaries for each goal to the Service Coordinator. These
summaries include:
• Progress toward the goal
• Satisfaction with the ISP
• Effectiveness of the supports
• Quality of the interventions
• Need for modification
The Service Coordinator writes a note in the participant's record stating that the plan was reviewed. The note specifies if there are changes in the plan and if the changes require a modification.

MODIFICATIONS
The changes requiring modification to the plan are:
• Change in the ISP goals.
• Change in the supports or services used.
• Change in the strategies used for unmet support needs.
• Change in the priority of services or supports.
• Initiation of or change in a behavior modification plan that uses an aversive or intrusive technique.
• A change in the location of a participant's home.

Procedure
When a team member believes a modification is needed, s/he contacts the Service Coordinator stating the reason for the change.

Appeal Rights
Participants have 30 days from the date of their Service Plan to initiate a written appeal. Massachusetts regulations 115 CMR 6.33-6.34 sets forth the appeal process for the Service Plan. Additional information regarding appeals is

contained in Appendix F-1.

PROCEDURE FOR DEVELOPING AN INTERIM, TEMPORARY PLAN OF CARE
In order to initiate services until a more detailed service plan can be finalized, an interim POC will be developed that is based on the results of the MASSCAP and all other available assessment information. This information will be used to identify the participant's needs and the type of services to meet those needs.

The Service Coordinator will include the participant and/or guardian in the development of the Interim Service Plan. This plan will become effective on the day services begin with a full planning meeting occurring no later than 90 days from that date. The Interim Plan will include both the waiver and non-waiver services to be provided, their frequency and who will provide the service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are a core part of the service planning process. Through the health, behavioral and safety assessments reviewed during the development of the Service Plan, potential risks to the individual's health and safety are identified. If the individual has a Risk Plan developed through the agency's Risk Management System, relevant components are discussed by the Team. The Team then develops a set of prevention strategies and responses that will mitigate these risks. The participant is involved in the development of these strategies to ensure that the responses are sensitive to their preferences. If through the assessment process and review it is determined that the individual may require a Risk Plan, the Team makes a referral for development of such a plan. The Service Plan also includes backup plans to address contingencies such as emergencies, including the occasions when a support worker does not appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant's health and welfare.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All waiver participants have the right to freely select from among any willing and qualified provider of waiver services. Upon referral to the waiver, the Service Coordinator provides each participant with information about supports available under the waiver and potential providers of these supports. This information includes an electronic index of providers available throughout the state and written material about DDS services and standards for services.

As part of the pre-planning activities for the annual service plan meeting, and as requested by the participant, the Service Coordinator also provides information about the range of services and supports offered through this waiver and other sources such as the state plan.

The Service Coordinator supports the participant in identifying appropriate providers and securing their services. Depending on the type of service provider, this support includes providing information regarding any licensure or certification requirements that must be met, the process to qualify as a provider of services including any relevant documentation that must be completed and assisting the participant in arranging for services. The individual is also informed of their opportunity to change providers and the process to do so.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Developmental Services maintains individualized member files at each area office. Service Plans are reviewed for content, quality, and required components through the Service Coordinator Supervisor Tool. The sample size is intended to meet requirements of a 95% confidence interval and a +/-5% confidence level. Data from a previously completed record audit of all of the Area Offices, as well as 2 years of data utilizing the SC Supervisor Tool, demonstrated a compliance rate of over 90%. Therefore, according to sound sampling methodology, DDS is able to modify the baseline distribution estimate from 50% to 90%. This enabled DDS to conduct a review of 251 Service Plans for the Residential Waiver. The sample is randomly generated by a computerized formula which generates the sample on a quarterly basis throughout the year and assures that each Service Coordinator Supervisor reviews the same number of reviews of Service Plans completed by Service Coordinators whom they supervise.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Service Coordinator has overall day to day responsibility for monitoring the implementation of the service plan to ensure that the participant is satisfied with waiver services, that they are furnished in accordance with the Service Plan to meet the participant's needs and achieve their intended outcomes and that they monitor health and welfare of participants. In addition there are several other quality management processes, conducted by other departmental staff as well as providers to assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices, and include but are not limited to:

a) incident reporting and management (described in Appendix G)
b) medication occurrence reporting (described in Appendix G)
c) restraint reporting,(described in Appendix G)
d) investigations process (described in Appendix G)
e) "trigger" reports (described in Appendix G)
f) bi-monthly site visits
g) risk assessment and management system
h) human rights and peer review processes
i) licensure and certification system
j) annual standard contract review process
k) periodic progress and update meetings
l) on-going contact with the participant and service providers.

Through the web based incident reporting and management system, service coordinators are notified of incidents, medication occurrences, and restraints that occur for individuals on their caseload. The system, known as the Home and Community Services Information System (HCSIS) alerts service coordinators in a timely manner, to any reportable event. Service coordinators are required to review and approve (typically with additional oversight and review by area and regional directors) action steps taken by the reporting provider. Incidents may not be "closed" until such time as action steps have been approved. approval of action. In addition, service coordinators and area offices receive monthly "trigger" reports, which identify individuals who have reached a certain threshold of incidents. Area Offices are required to review all "trigger" reports to assure that appropriate action has been taken to protect the health and welfare of participants.

The Department also has an extensive risk management system. Area based risk management teams identify, assess and develop risk management plans for individuals identified who require specific supports in order to mitigate risk to health and safety. Plans are reviewed on a regular basis by the area teams to assure their continued efficacy.

Frequency of direct in-person contact with the waiver participant is based on individual needs. Each waiver participant has direct in-person contact at least every six months. The amount of direct contact is related to a number of variables including whether the participant has a risk plan in place, the number of potential providers who have daily contact with the participant, the frequency of program monitoring activities within the provider site, the frequency and type of family citizen monitoring etc. In response to incidents reported through HCSIS the system produces “trigger reports” which provide additional information to the TCM about the need to potentially increase direct in-person contact. Individuals with changing needs are seen more frequently based on their individual needs. Targeted case managers review progress notes from providers and maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact. Individuals who have not received at least one waiver service monthly, receive direct in-person contact in the following month.

The service planning process includes backup plans to address contingencies which may impact the waiver participant. The ISP team assesses the participant’s needs and includes a review of the natural and generic supports available to assist the participant. Monitoring for effectiveness of backup plans is the responsibility of the Support Planning Team led by the Targeted Case Manager. As part of the ISP the safety assessment is reviewed and a determination is made about whether there is a need for a risk assessment. The outcome of the safety assessment and the risk assessment determine the type of back-up plan required. Therefore, the back-up plans vary by person and by his or her circumstances. Secondly, all incidents are reported in HSCIS including the examples cited in the question. There is a broad-based on-call system in place throughout the state including an emergency hotline with 24/7 response. Individuals and families are provided with information on who to contact in an emergency and how to access the hotline number. The Supervisory Tool is also used to uncover whether the back-up plans have been effective. Agency providers are subject to licensure and certification which is the underpinning for addressing health and safety issues which offers an additional perspective about the effectiveness of back-up plans. The provider of waiver services must also develop a Continuity of Operations Plan (COOP) to deal with emergencies. All are also connected to the Massachusetts Emergency Management Agency.

DDS uses the Supervisory Tool to monitor the access to non-waiver services on a quarterly basis. TCM Supervisors routinely review TCM notes to monitor participant access to non-waiver services in the service plan including health services.

Area offices, typically service coordinators, also conduct bi-monthly site visits of 24 hour residential supports and quarterly site visits of less than 24 hour supports. Service coordinators utilize a standardized site visit form that

reviews such issues as the condition of the homes, interactions and knowledge of staff of the individual and his/her needs, and whether the individual's health and clinical needs are being addressed. Issues are identified and follow up is conducted by either the service coordinator, program monitor or other identified area office staff.

DDS also requires all providers to maintain active human rights committees as well as site based human rights officers. Human rights committees review all behavioral interventions and restraints to assure that participants' rights have been reviewed and safeguarded. Peer review committees are required to review all Level II behavioral interventions to assure that they are clinically sound and contain all necessary components. There are no Level III interventions permitted. The Human Rights Committees review Level II interventions to insure that they comply with the DDS regulations and to insure that there is no unauthorized use of Level III interventions. The Human Rights Committee function to insure that the behavioral interventions described and the data collected present a coherent plan and that the treatment is effective. DDS as part of its Survey and Certification process reviews whether all behavioral interventions and restraints have all required components and have undergone all required reviews. This includes 1) the composition of the Human Rights Committee. 2) obtaining informed consent from the individual and/or guardians, 3) assuring that all behavior plans are in written format, 4) whether all behavior plans have all the required components, 5) reviewed all of the required reviews which include the ISP team, the Human Rights Committee, individual and/or guardian, Peer Review and a Physician Review, 6) that the data is maintained and used to determine the efficacy of the intervention and that 7) restrictions for one individual do not impinge on the rights of other individuals.

As an additional safeguard for individuals, all providers of residential, day, placement and site based respite services are required to be licensed and certified to assure that they are achieving foundational safeguards and positive outcomes in the lives of individuals they support. This oversight process selects a sample of individuals and reviews how the provider is supporting health, safety, choice, control, growth and accomplishments, community integration and relationships. Service coordinators receive a copy of the outcomes for each individual reviewed. Follow up is conducted on individuals as well as the agency as a whole to assure that participants are getting the services identified in their plans and that their health and safety is protected.

The Annual Standard Contract Review Process is conducted by Area Directors and compiles data from a variety of sources including the licensure and certification reviews, bi-monthly site visits, incident reports and performance based objectives. The process allows the area offices and agencies to identify how agencies are supporting individuals to be healthy and safe and to achieve overall quality of life.

Service coordinators conduct semi-annual reviews of the service plan and its continued efficacy in assisting individuals to reach their goals and objectives. Providers submit progress reviews and modifications may be made if deemed necessary.

As described more fully in the Quality Improvement Section of Appendix D, the Department is developing a service coordinator supervisory tool, in addition to its existing ISP checklist, which will further enhance the oversight and monitoring of the service plan.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP a1. Percent of service plans that reflect needs identified through the assessment process. (Number of service plans that address needs identified during the assessment process/Number of service plans reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordinator Supervisory Review Tool/ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP a2. Percent of service plans that reflect personal goals identified through the assessment process (Number of service plans that address personal goals identified during the assessment process/Number of service plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordinator Supervisor Review Tool/ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified**

		Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP a3. Percent of individuals reporting that they get the services that they need. (Number of individuals reporting they get the services they need/Number of individuals interviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random sample selected from total state adult population served.
	☑ **Other** Specify: Every two years	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every two years

Performance Measure:
SP a4. Percent of service plans that have required assessments. (Number of service plans with required assessments/Number of service plans reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:

Service Coordinator Supervisor Review Tool/ ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
SP a5. Percent of service plans that have been developed in accordance with waiver requirements as indicated by the inclusion of all required components, including all required assessments, support strategies, choice forms, LOC & POC. (Number of service plans developed in accordance with waiver requirements as indicated by the inclusion of all required components/Number of service plans reviewed)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordinator Supervisor Tool/ ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP c1. Percent of service plans that are completed and/or updated annually. (Number of individuals whose service plans are completed and/or updated annually/Number of individuals with service plans reviewed.)

Data Source (Select one):
Other

If 'Other' is selected, specify:
Service Coordinator Supervisor Review Tool/ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
SP c2. Percent of service plans updated when warranted by changes in participants' needs. (Number of service plans updated when needs change/number of participants reviewed with changing needs.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
ervice Coordinator Supervisor Review Tool/ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP d1. Percent of individuals who are receiving services according to the type, amount, frequency and duration identified in their plan of care. (Number of individuals who are receiving services according to the type, amount, frequency and duration identified in their plan of care/Number of individual plans of care reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordinator Supervisory Review Tool/ISP Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP e1. Percent of individuals reporting that they were given a choice of services and service providers. (Number of individuals reporting that they were given a choice/Number of individuals surveyed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Random sample selected from total state adult population served.
	☑ **Other** Specify: Every two years.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every two years.

Performance Measure:
SP e2. Percent of service plans that contain a signed form indicating that participant was informed of his/her choice between service providers and method of service delivery (Number of service plans that contain a signed form/Number of service plans reviewed.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordinator Supervisory Tool/ISP Checklist.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Sample of each service coordinator's caseload
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Performance Measures SP a1., SP a2. SP a4., SP a5., SP c1., SP c2., SP d1., SP e2.
Service coordinator supervisors will review a sample of ISP's of each of the service coordinators they supervise utilizing the Service Coordinator Supervisory Tool which is currently under development (see timelines below). The tool has two components. The first is a checklist that is completed with every ISP submitted for review and approval. The second is a qualitative review which includes discussion with the service coordinator as well as review of supplementary material. This is done on a quarterly basis. Included is a review of documentation (including service coordinator notes, site visit forms, and the ISP) and discussion with the service coordinator to verify that service planning and implementation requirements have been met. Each indicator on the tool is rated according to whether it met the applicable standard.

Performance Measures SP a3., SP e1.
Survey and Certification staff conduct approximately 600 face to face interviews utilizing the National Core Indicators survey instrument. The tool is administered every other year. Results are analyzed by HSRI and are used to measure DDS's own performance and key indicators as well as to benchmark DDS system performance against other states.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measure SP a3., SP e1.
Systemic data from the consumer surveys are analyzed and reviewed by the Quality Council and become the subject of overall service improvement targets. Both of these performance measures are drawn from data collected from the conduct of the face-to-face National Core Indicators (NCI) survey. The NCI surveys are

anonymous and therefore the performance measures indicated here are intended to supplement more specific information regarding whether individuals are getting the services they need and whether they are given a choice of services gathered through the Service Coordinator Supervisor Tool. These NCI data are reviewed collectively with data from the Service Coordinator Supervisor Tool by the Quality Council and Central, Regional and Area management staff to determine what the issues are and what improvements need to be made.

Performance Measures SP a1., SP a2. SP a4., SP a5., SP c1., SP c2., SP d1., SP e2.
Ratings for all individuals reviewed as part of the sample for the Service Coordinator Supervisor Tool are entered into the HCSIS database specifically created for this purpose. Standards rated as "not met" are subject to correction by the service coordinator. The service coordinator supervisor follows up and documents corrections made.

Systemic issues are identified and reviewed by the waiver unit. Quality improvement plans may be developed that address service coordination and service planning issues that are identified.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Human Services Research Institute	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every two years.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed

budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Subject to the limits described in this waiver application, participants in this waiver may lead the design of their service delivery through a participant directed process. The Department of Developmental Services will provide consumer-directed options for participants who choose to direct the development of their Individual Service Plans and to have choice and control over the selection and management of waiver services. Individuals may choose to have either employer authority or budget authority or both. As part of the initial and on-going planning process of assessment and enrollment into the waiver, the individual is provided information by the Regional Eligibility Team and/or the Area Office about the opportunity to self-direct once eligibility has been established. If the individual indicates a desire to self-direct they will be afforded information about the opportunity to select a Support Broker from the qualified roster of brokers. The roster consists of Independent Support Brokers and Specialized DDS Support Brokers. The participant may also recommend an individual who can perform brokerage functions subject to the training and qualifications established by the Department. An individual who volunteers to function as a support broker is also subject to the training and credentialing requirements. Support brokerage is delivered as an administrative cost and is not included in the individual's budget.

All individuals who self-direct will have a Targeted Case Manager to assist them to direct their plan of supports. Individuals who self direct by hiring their own staff will have either a Specialized DDS Case Manager (Support Broker) or an Independent Support Broker to assist them to direct their plan of individual support. In addition to case management activities that the DDS worker provides, as Support Brokers they assist individuals to access community and natural supports and advocate for the development of new community supports as needed. They assist individuals to monitor and manage their Individual Budgets. Brokers may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist individuals to develop an emergency back up plan and may assist individuals to access self-advocacy training and support. When the participant selects an Independent Support Broker, the role of the DDS Case manager encompasses solely case management functions.

The amount of required support brokerage is dependent on the individual budget and the need level of the participant. The support broker assists individuals to direct their plan of support. The planning process includes the participant, responsible legal representative, the Targeted Case Manager, the Support Broker if identified at the time, and may include other individuals of the participant’s choosing, and other clinicians and supporters appropriate to the needs of the individual. The initial step of the planning process results in a service plan that indicates the type, frequency, and duration of the waiver services necessary to address the participant’s support needs. The individual then has the opportunity to direct some or all of their services as long as the services are included in the waiver as allowable for self-direction. Not all services can be self-directed. Every year at the time of the Individual Planning process, individuals are given the opportunity to self-direct. The team will assess the individual’s ability to self-direct and what supports will be needed to insure success.

The budget allocation is determined as part of the person-centered planning process and is based on the outcome of the individual assessment of need and the costing out of the chosen services based on the established rate ceilings. Individuals may choose to self-direct some or all of their services.

Individuals who self-direct may choose to be the direct employer of the workers who provide waiver services or may

select a qualified Agency with Choice. If the Agency With Choice model is chosen, the Agency will be handling payroll and taxes etc. The Agency with Choice is the employer of record for employees hired to provide waiver services for the individual; however, the individual maintains the ability to select, train, and supervise these workers on a daily basis. The individual may refer prospective employees to the Agency with Choice for employment. In both arrangements the individual and/or family have responsibility for managing the services they choose to direct.

Individuals who self-direct and hire their own workers have the authority to recruit, hire staff, verify qualifications, determine staff duties, set staff wages and benefits within established guidelines, approve time sheets, provide training and supervision, evaluate staff, and terminate staff employment. Once the person-centered plan and budget is complete, the service budget is forwarded to the Financial Management Service for implementation of the plan and the budget. The participant indicates in what manner and from whom the approved waiver services will be purchased.

The Financial Management Service entity performs the payment tasks associated with the purchase of waiver services and supports. If the participant chooses the employer authority option and functions as the common law employer, the Fiscal Management Service provides fiscal services related to income and social security tax withholding and state worker compensation taxes. The FMS provides monthly reports and expenditures with disbursements and remaining fund balances so that the individual can monitor his/her budget. The FMS also executes the agreements with providers of services, assists participants in verifying support worker citizenship status, collects and processes time-sheets of support workers, pays invoices for approved goods and services as approved in the support plan. The FMS also does the final collection of all qualification data and conducts Criminal Offender Record Inquiries (CORI) and maintains a list of qualified providers. The FMS executes and holds Medicaid provider agreements on behalf of the Medicaid agency.

The Fiscal Management Service is required to be utilized by individuals and families who choose to hire their own staff and self direct some or all of their waiver services in their Individual Plan. The service will be delivered as an administrative cost and is not included in the individual's budget.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals must demonstrate an ability and desire to self-direct. This will be assessed during the service planning process by the Team and reviewed annually. The Department will work with individuals who are determined to require significant assistance to self-direct their services. The Support Broker will provide that assistance. All individuals who exercise employer authority are required to utilize a Support Broker. Should evidence arise that an individual who is self-directing all of his/her services is no longer able to do so, s/he will be offered the option to have a surrogate volunteer assist with their self-direction decisions. If they do not wish to use a surrogate they will be denied the opportunity to continue and will be required to receive supports through a traditional provider. Appeal rights will be granted. Participant direction opportunities are available to all individuals enrolled in this waiver. Services which cannot be self-directed are the following: Facility based Respite, Day Habilitation Supplement, Transportation that is part of a day program or a contracted route, Stabilization, Community Based Day Supports and Center Based Day Supports and Residential Habilitation. Other services require prior authorization including: Behavioral Supports and Consultation, Home Modifications and Adaptations Vehicle Modifications. Specialized Medical Equipment and Supplies, Assistive Technology, Occupational, Speech, and Physical Therapy are authorized as part of the Service Planning Process.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction will be provided to each individual. The range of options will be discussed as part of the planning process and throughout the implementation of the support plan by the Targeted Case Manager. Participants are provided written material about their responsibilities of being an employer. The FMS acts to insure that all tax filings and other payroll associated costs are handled. On behalf of participants the FMS arranges for a worker's compensation policy which provides protection for the waiver participant as well as the employee. Participants are informed of these components of the program. Once the individual has selected the participant directed option, additional information and a handbook about the Fiscal Management Service and the requirements are provided. The waiver provides for both employer and budget authority. The FMS has the responsibility for providing fiscal services related to income and social security tax withholding, and state worker compensation taxes. With budget authority the participant has the authority to manage budget allocations through the FI to purchase goods and services that have been authorized in the plan. For those who choose to self-direct their services, Support brokers are available to provide assistance. The Fiscal Management Service verifies that individual provider qualifications and training requirements are met prior to employment and the appropriate forms to document that training are completed. The Fiscal Management service is responsible for processing Criminal Offense Record Inquiries.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The state's practice is to allow participants the opportunity to self-direct their waiver services independently, if they are able to do so, or with assistance, if needed from a legal representative of the participant, family members, or a non-legal representative chosen by an adult participant. In both cases the representative of the participant may not be paid for directing the services. When a non-legal representative directs services on behalf of the participant the participant executes a limited power of attorney which spells out the decision-making authority the non-legal representative can exercise.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Speech Therapy	☐	☑
Respite	☑	☑
Peer Support	☑	☑
Individualized Day Supports	☑	☑
Family Training	☑	☑
Individual Goods and Services	☐	☑
24-Hour Self Directed Home Sharing Support	☑	☑
Transportation	☑	☑
Occupational Therapy	☐	☑
Specialized Medical Equipment and Supplies	☐	☑
Vehicle Modification	☐	☑
Individualized Home Supports	☑	☑
Assistive Technology	☐	☑
Adult Companion	☑	☑
Behavioral Supports and Consultation	☑	☑
Home Modifications and Adaptations	☐	☑

Waiver Service	Employer Authority	Budget Authority
Transitional Assistance Services	☑	☑
Physical Therapy	☐	☑
Individual Supported Employment	☑	☑
Chore	☑	☑
Live-In Caregiver	☐	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services are provided through a financial management service entity. The designation was the result of an open, competitive procurement. At the time of the agreement, the FMS was required to meet the Commonwealth's pre-qualification requirements, which emphasize that the FMS must demonstrate operation in a financially sound and responsible manner through a review of references, credit history and financial statements.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Financial Management Services are furnished as an administrative activity between the Department of Developmental Services and the Fiscal Management Service. Currently, financial management services are provided through Public Partnerships Limited (PPL) as the result of an open and competitive procurement. The agreement between DDS and PPL provides for a monthly Financial Management Services fee per client served.

PPL reports budget status to the Department and to participants on a monthly basis. PPL executes individual provider contracts with each waiver participant for Fiscal Management Services and with the participant and the provider of direct supports and services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Processes Criminal Offense Record Inquiries(CORI); provides information to participants, provides a help line and maintains a "good to provide" list.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other services and supports**

Specify:

Assures that payment is made to only those providers that have qualified to provide supports.

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

FMS provides an enrollment packet to each individual to whom it provides fiscal intermediary services under their state contract. The enrollment packet includes the forms and information (employee application, fact sheet on employer liability and safety, Criminal Background checks, Individual Provider agreement, employee and Vendor Agreement forms, Individual Provider Training Verification Record and training materials.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Department of Developmental Services is responsible under its competitive procurement and negotiated contract to manage the performance of the FMS. The Department has established performance metrics and requires that its FMS meet them and has established a process of remediation if they do not achieve them. The FMS maintains monthly individual budgets on a management information system and provides monthly financial reports to both participants and to the Department. Monthly invoices contain specific line items

identifying the disbursements made on behalf of the participants. Monthly FMS reports reconcile expenditures for a participant with that participant's approved individual budget. Quarterly reports by the FMS analyze expenditures by 1) types of goods and services purchased, 2) similar categories of supports and services plans and reconciliation reports. There are also reports that analyze accuracy and timeliness of payments to providers and accurate and timely invoicing for goods. Reports examine the monthly spending and track this against the allocation. The FMS is also required to have an available line of credit as part of its contract to insure that waiver participants do not experience any disruption in their waiver services. The FMS is required to maintain a log of complaints. The Department includes individuals using the FMS in its National Core Indicator Consumer sample.

DDS has quarterly monitoring meetings with its Fiscal Intermediary, Public Partnerships, Limited (PPL), weekly phone calls to address business process issues that may arise and ad hoc calls whenever issues occur outside of these regularly scheduled times.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and what types of supports will be required to assist them. Participants who either choose to self-direct all of their services or who want employer authority will be required to have a support broker to provide information and assistance to support self-direction. Each participant will also have a Targeted Case Manager whose duties are specified in the State Plan. The role of the Targeted Case Manager is to monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the DDS case manager (TCM) in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. Case managers support individuals to be actively involved in the planning process. Case managers share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Case managers assist the person to develop an individual budget and assist with arranging supports ands services as described in the plan. They also assist the individual to monitor services and make changes as needed. Case managers share information regarding the ability to change providers when individuals are dissatisfied with performance. As described in Section E.1.a, individuals who self direct by hiring their own staff will have a case manager or a specialized case manager, called a DDS support broker, to assist them to direct their plan of individual support. In addition to case management (TCM) activities, the DDS Support Brokers assist individuals to hire, train and manage the support staff, negotiate provider rates, develop and manage the individual budget, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills. These additional duties are considered outside the scope of the TCM service so the time/costs are not included in the rate setting methodology for TCM.

Another option for those who self-direct is to have a DDS case manager (TCM) and Independent support broker. Independent Support Brokers provide support and consultation to individuals and/or their families to assist them in directing their own plan of individual support. The services included are: Assistance with developing a natural community support network, Assistance with managing the Individual Budget, Support with and training on how to hire, manage and train staff, Assistance with negotiating rates and reimbursements, Collaboration with DDS Targeted Case Managers and Participation in participant's planning meetings or is made aware of the participant's individual plan and goals from both the participant and Targeted Case Manager, Assistance in accessing community activities and services, including helping the individual and family with

day-to-day coordination of needed services,and the Development of an emergency back up plan.

Some participants who have limited budgets or only self-direct discrete purchases of individual goods and services, or home adaptations may not be required to use a support broker. This may be because they are skilled enough to complete the tasks themselves as determined through an assessment, or they have sufficient natural supports that can assist them, or the use of the FMS is time-limited and for discrete activities or purchases. In these cases general oversight responsibilities of the TCM are sufficient to monitor the participant's self-direction activities.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech Therapy	☐
Respite	☐
Residential Habilitation	☐
Peer Support	☐
Individualized Day Supports	☐
Family Training	☐
Individual Goods and Services	☐
24-Hour Self Directed Home Sharing Support	☐
Transportation	☐
Occupational Therapy	☐
Community Based Day Supports	☐
Center Based Day Supports	☐
Specialized Medical Equipment and Supplies	☐
Group Supported Employment	☐
Vehicle Modification	☐
Individualized Home Supports	☐
Assistive Technology	☐
Adult Companion	☐
Behavioral Supports and Consultation	☐
Home Modifications and Adaptations	☐
Transitional Assistance Services	☐
Day Habilitation Supplement	☐
Physical Therapy	☐
Stabilization	☐
Individual Supported Employment	☐
Chore	☐
Live-In Caregiver	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) When DDS provides Support Brokerage assistance the workers are state employees; independent support brokers are qualified by the state and available through the Fiscal Intermediary.

(b) The independent support brokers are qualified through an open procurement process. Support brokers who meet the qualifications may be hired by waiver participants and are paid through the Fiscal Intermediary at an established rate. State workers are compensated through the state's Human Resources database.

(c) The Support Broker assists the legal representative of the participant or the participant in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long-term needs, developing options to meets those needs and accessing identified waiver supports and waiver services. Participants or their legal representatives may also receive information on recruiting and hiring homemaker or chore services, managing workers and providing information on effective problem solving and communication. The function includes providing information to ensure that the participant or
legal representative understand the responsibilities in directing their own services; The extent of assistance furnished to the participant is discussed by the team and specified in the service plan. The Support Broker will assist in developing a person-centered plan to ensure that the needs and preferences are clearly understood and reflect in the plan. In addition the Broker will assist in arranging for, directing and managing waiver services. The Brokers will focus on the following sets of activities in support of participant-directed services:
- Assist the individual to recruit, train and hire staff
- Assist the individual in reviewing requests for waiver services that require prior authorization
- Review individual budgets and spending on a quarterly basis
- Facilitate community access and inclusion opportunities as it relates to budgeting
- Facilitate the development of a person-centered plan of care
- Monitor and assist the individual participant when revisions are needed
- Assist the participant in working with the Fiscal Management Service to recruit, screen, hire, train, schedule, monitor and pay support workers
- Discuss the status of activities with Targeted Case Manager

(d) DDS Support brokers are assessed through the state's personnel performance system and through the Service Coordinator Supervisory Checklist Tool; Independent Support Brokers are reviewed by the Fiscal Intermediary and periodically reviewed by the state agency.

(e) DDS Supervisory staff assess performances of its DSS support brokers and the Waiver Unit reviews the qualification for the Independent Support Brokers.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If after all efforts to support a participant in directing his/her services have been attempted and the waiver participant voluntarily chooses to terminate this method of receiving services, the Department of Developmental Services would seek to continue supports through a traditional provider to meet the individual's health and welfare needs. When appropriate, the Department would alter the plan of care to ensure that the service plan meets the needs of the individual and to ensure health and safety during the transition from participant-directed services to a more traditional provider based service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each individual who self-directs by hiring his or her own workers has an Agreement for Self Directed Supports describing the expectations of participation. As part of this agreement, the individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the requirements with or without intent may disqualify the individual from self-directing-services. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports.

Although the Department will work to prevent situations of involuntary termination of self-direction, they may be necessary. On-going support and monitoring by both the Targeted Case Manager and the Support Broker may not be adequate to ensure that the participant's health and welfare can be assured. In that case the participant will be given notice and an opportunity for a fair hearing. Reasons for termination include but are not limited to a) refusal to participate in the development and implementation of the Individual Planning Process, b) the continual inability to manage the budget, c) multiple attempts to hire individuals who are inappropriate, d) on-going inability to locate, supervise, and retain employees, d) failure to submit time-sheets in a timely manner, e) inadequate protection for health and welfare, f) changing needs of the waiver participant which require greater oversight and monitoring on a daily basis, g) authorization of payment for services or supports that are not in accordance with the individual plan, and h) commission of fraudulent or criminal activity associated with self-direction. The commission of fraudulent or criminal activity may also result in termination from the waiver.

For an involuntary termination of participant direction the individual and the support team meet to develop a transition plan and modify the Individual Service Plan. The Targeted Case Manager ensures that the participant's health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2		100
Year 3		100
Year 4		100
Year 5		100

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Agencies with Choice will be permitted and encouraged. DDS will require specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees and manages potential conflict of interest, and requires periodic participation in DDS sponsored training and events in consumer-direction. If the Agency with Choice model is chosen, the Agency will be handling payroll and taxes etc. DDS will require that there are adequate safeguards in place for the qualifications of individuals and to provide financial oversight. DDS procured Agencies with Choice and the list of qualified Agency With Choice providers is available on the state's website of approved providers.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Payment for these investigations does not come from the individual's budget but is made either by the FMS as part of its cost of doing business or through the Agency with Choice.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including

how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant-directed budget amount for waiver services and goods over which the participant has authority is established through an individual assessment process that determines the waiver services needed to ensure the participant's health and welfare and to prevent the risk of institutionalization. The specific cost of these supports is established through a review of the type, frequency, and duration of the supports needed. Also, considered are the availability of natural and generic supports and State Plan or other services available to the individual. Costs are estimated based on an analysis of the needs of participants with similar needs in similar services. Use of the standard MASSCAP assessment process ensures that the budget methodology is applied consistently to each waiver participant. Waiver rates are approved by the Division of Health Care Finance and Policy and are publicly available upon request.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Budget development is an integral part of the support planning process which includes needs assessment and identification of supports to meet those needs. (115 CMR 6.00) Based on this plan, a funding amount for each component of service is identified and a budget established to support the implementation of the plan subject to the waiver cost limit on services and limits on particular services. The participant is part of the budget planning development and is informed of the allocated amount. The amount is then documented. The service planning process includes communication about appeal rights and the process for appeal. Massachusetts' regulations at 115 CMR 6.33-6.34 set forth the appeal process for the Service Plan.

Each participant can expect at least monthly contact with either their Targeted Case Manager or the Support Broker to determine if any adjustments are needed in their budget. This is a fundamental component of their regular communication. If at any time there is a significant change in the participant's life, an adjustment can be made to ensure health and safety.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Adjustments are changes to the existing individual budget in an amount or type of waiver services they are receiving without a change in funding. The participant is free to make adjustments to his/her individual budget within the services they are receiving, provided that they do not exceed the limits established in the waiver and are services the individual has an assessed need to receive. Any changes requiring the addition of new service(s) or the deletion of an existing service that address the health and safety needs of the participant, requires the review and approval of the Targeted Case Manager. When

the participant or team member believes that a modification is needed, they contact the Targeted Case Manager stating the reason for the change. This request will trigger the need for a new assessment. The Targeted Case Manager arranges a meeting to discuss the requested changes and makes a determination. Modification reasons include changes to goals, supports and strategies, and changing needs of the individual. A change in services either a deletion or the addition of new services will require a change in the Plan of Care. Changes in the amount of waiver services are documented by revisions to the Plan of Care at the time of the ISP. Prior to making changes in the types of waiver services provided, DDS administers a new MASSCAP assessment which informs DDS about what types of waiver services are needed. This then results in a formal modification of the Individual Service Plan and the generation of a new POC.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS operates a web-based electronic information system to:

Track allocations and payment of invoices;

Track and monitor billings and reimbursements by participant identification, name, social security number, service type, number of service units, dates of services, service rate, provider identification and participant's support plan;

Track and monitor utilization review and issue monthly reports to the Department and the participant;

Any potential for over-utilization or under-utilization of the budget or non-compliance with the support plan, will be apparent based on the Department's review of monthly participant specific expenditure reports. Additionally, there is ongoing communication between the Support broker, the Targeted Case Manager and the FMS.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Procedures for notifying individuals of the opportunity to Request a Fair Hearing encompass the following adverse actions; (a) not providing an individual the choice of home and community-based services as an alternative to institutional care; b) denying an individual the service(s) of his/her choice or the provider(s); and (c) actions to deny, suspend, reduce or terminate services.

Individuals are afforded the opportunity to request a Fair Hearing in all instances when they: (a) are not provided the choice of home and community-based services as an alternative to institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; and/or their services are denied, suspended, reduced or terminated.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process by letter from the Waiver Management Unit. If entrance to the waiver is denied, the individual is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that the individual is fully informed of his right to a Fair Hearing, the written information when necessary will be supplemented with a verbal explanation of the Rights to a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g. services are denied, reduced or terminated), the participant is notified in writing by letter from the Area Director or designee on a timely basis in advance of the effective date of the action. The notice includes information about how the participant may appeal the action by requesting a Fair Hearing and provides, as appropriate, for continuation of services while the participant's appeal is under consideration. Copies of the notices are maintained in the individual's record. It is up to the participant to decide whether to request a Fair Hearing.

The notices regarding the right to a Fair Hearing in each instance provides a brief description of the appeals process and instructions regarding how to appeal. The notices refer the individual and/or legal representative to the DDS regulations at 115 CMR 6.33-6.34 which describe the procedure for requesting and receiving a Fair Hearing. Informal conferences and Fair Hearings are conducted in accordance with the Massachusetts Administrative Procedures Act and the Standard Adjudicatory Rules of Practice and Procedure. See 801 CMR 1.00 et seq. Individuals are notified that they may appeal Fair Hearing decisions to the Superior Court pursuant to M.G.L. c. 30 A (the Massachusetts Administrative Procedures Act.) The right to a fair hearing within time frames in Federal regulations is not impeded by any other method of problem resolution. The time frame for any other state problem-resolution activity runs concurrent with a person's right to a fair hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Since July, 2006, DDS has been utilizing a web based incident reporting system, based upon the Pennsylvania Home and Community Services Information System (HCSIS) system. The incident reporting system provides invaluable information regarding individual incidents, immediate and long range actions taken as well as aggregate information that informs analyses of patterns and trends. Providers are required to report incidents when they occur and service coordinators are required to report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing person, injuries, are examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, property damage, and behavioral incident in the community are examples of incidents requiring a minor level of review. The HCSIS system is an integrated “event” system and as such medication occurrences and restraint utilization are also reported. These processes are more fully described in this appendix. Incidents classified as minor are reported within 3 business days. Minor incidents may be elevated to major, if determined necessary. Major incidents are reported within 1 business day. This does not relieve the provider of the responsibility for immediately reporting major incidents by phone or e-mail to Area Offices of DDS. Immediate and longer term actions steps are delineated and must be reviewed and approved by DDS area staff for minor incidents and area and regional staff for major incidents. An incident cannot be considered closed until all appropriate parties agree on the action steps to be taken. Standard management reports for area, regional and central office staff for purposes of follow up on provider and systemic levels are provided on a monthly basis. Aggregate data is reported by numbers and rates for each area and region on a quarterly basis.

In addition to the incident reporting system, all alleged instances of abuse or neglect are reported to the Disabled Persons Protection Commission (DPPC). DPPC is the independent State agency responsible for screening and investigating or referring for investigation all allegations of abuse or neglect for individuals with disabilities between the ages of 18 and 59. Mandated reporters as well as individuals and families report suspected cases of abuse or neglect directly to the DPPC. DPPC reviews all reports, then determines and assigns investigation responsibility.

(Applicable DDS regulations – 115 CMR Ch. 9.00)

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As part of their responsibility, providers are required to inform all participants and families of their right to be free from abuse and neglect and the appropriate agency to whom they should report allegations of abuse, neglect or exploitation. Individuals and their families are given the information both in written and verbal formats. As part of their role, service coordinators also inform individuals about how to report alleged cases of abuse or neglect. Quality Enhancement surveyors conducting licensure and certification reviews check to assure that individuals and guardians have received information regarding how to report suspected instances of abuse or neglect. They also check to assure that the information is imparted in the format most appropriate to the individual's or family's learning style.

As part of its on-going commitment to providing participants with information to prevent and report abuse or neglect, DDS has partnered with self-advocacy groups such as Massachusetts Advocates Standing Strong to support "Awareness and Action" a training program taught by and for self-advocates regarding how to prevent and report abuse. In addition, DDS is a partner with a private provider as part of a Robert Wood Johnson grant to train self-advocates in self defense and to support providers to create a culture of zero tolerance for abuse/neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As mentioned in G-1-b, there are two distinct processes for reporting incidents – one for incidents (classified as minor or major) and one for reporting of suspected instances of abuse or neglect. A reported incident may also be the subject of an investigation, but the processes are different and carried out by different entities. The processes are described below.

Minor and major incidents are reported by the staff person observing or discovering the incident. A major incident is immediately reported verbally to the service coordinator in the DMR area office. The incident is entered into the electronic web based system. A major incident must be reported within 1 business day; a minor incident within 3 business days. The initial report is reviewed by the service coordinator to assure that immediate actions have been taken to protect the individual. A final report is submitted by the provider which includes the action steps that will be taken beyond those already identified. Both minor and major incident reports are reviewed by the service coordinator. Major incidents are escalated to the regional level for review. The final report, which includes action steps, must be agreed upon by both the provider and DDS. If DDS does not concur with the action steps, the report is sent back to the provider for additional action. Incident reports are considered closed only after there is consensus among the parties as to the action steps taken. A similar process is in place for response to medication occurrences and restraint utilization. In the event of a medication occurrence, the review is completed by the regional Medication Administration Program (MAP) coordinator, who is an RN. Restraints are reviewed by service coordinators and regional human rights specialists.

Incidents that rise to the level of a reportable event, i.e. allegation of abuse or neglect, potentially subject to investigation, are reported to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all reports and makes the determination as to whether a reported event meets the criteria to require an investigation. It then refers the case to the appropriate agency for investigation. DPPC can decide to conduct the investigation itself, refer the case to the DMR Investigations Unit for investigation, or refer the case to law enforcement entities as the circumstances require. All reports of abuse or neglect are processed by trained, experienced staff. When deemed necessary, immediate protective services are put into place to ensure that the individual is safe while the investigation is completed. Once referred for investigation, investigators have 30 days to complete their investigation and issue findings. By regulation (DDS 115 CMR 9.00)and upon request, the alleged victim, the alleged abuser, and the Reporter can receive a copy of the report. Completed investigations are referred to area complaint resolution teams (CRT) comprised of DDS area staff and citizens. It is the CRT's responsibility to develop an action plan and assure that the recommended actions are completed.

In addition, the Human Rights Committee (HRC) for the provider agency responsible at the time of the incident is a

party to all complaints regarding that agency. In addition to ensuring the alleged victim has access to support for filing complaints of abuse or mistreatment, the HRC is responsible for applying their knowledge of the persons and programs involved and ensuring that any investigation has considered all aspects of the incident. They have the power to appeal the disposition of the complaint, the decisions of the investigation, or the action plan submitted to resolve the investigation. If any major or minor incident appears to involve or impinge on the human rights of an individual, the HRC must be informed of the incident and outcomes.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The single State agency retains administrative authority for the HCBS waiver, although the sub-agency DDS has responsibility for oversight of the critical incidents system. The responsibility for overseeing the reporting of and response to critical incidents rests with the DDS as the operating agency for the waiver. Oversight of the incident management system occurs on three levels- the individual, the provider and the system. As previously mentioned, the incident reporting and management system is a web based system. As such incidents are reported by providers according to clearly defined timelines. The system generates a variety of standard management reports that allow for tracking of timelines for action and follow up as well as for tracking of patterns and trends by individual, location, provider, area, region and state. On an individual level, service coordinators are responsible for assuring that appropriate actions have been taken and followed up on. On a provider level, program monitors in area offices track patterns and trends by location and provider. On a systems level, area directors, regional directors and central office senior managers track patterns and trends in order to make service improvements. Data from the incident management database are incorporated into the annual standard contract review with providers and performance based objectives. Licensure and certification staff review incidents and provider actions when they conduct their surveys.

A central office risk management committee reviews all incident data on a system wide basis. The committee meets monthly and reviews and analyzes systemic reports generated on specific incident types. Quarterly reports are disseminated to each area and region detailing the numbers and rates of specific incidents. In addition “trigger” reports based upon 10 thresholds developed by the committee are disseminated to each area monthly. This serves as an additional safeguard to assure that Areas are aware of, have taken appropriate action when there are a series of incidents that reach the trigger threshold and to follow up on potential patterns and trends for the individuals they support.

In addition to the processes mentioned above, staff in the Office of Quality Management conduct a bi-weekly review of identified risk categories to assure that they received the appropriate reviews. A report is generated which goes to Regional Risk Managers. In addition, the bi-weekly report with a synopsis of key incidents is distributed to Senior DDS management staff, including the Commissioner.

Finally, on a quarterly basis, a random sample of “trigger” reports are selected for review by the Central Office Director of Risk Management and the Regional Risk Managers. The sample gets reviewed to determine whether action was taken, whether the actions were consistent with the nature of the incident and whether additional actions are recommended.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Safeguards pertaining to the use of restraints are spelled out in detail in DDS regulation CMR Chapter 5.11. Restraints are permitted only in the event of an emergency and must be in writing. An emergency is defined as a situation where there is the occurrence of serious physical assault or self-injurious behavior, or the imminent threat of either. Seclusion is expressly prohibited. Physical and chemical restraints are permitted consistent with the safeguards outlined below. Mechanical restraint is prohibited unless a waiver has been granted by the Department's Office for Human Rights for a specific individual. There are no waiver providers who are authorized to use Level III interventions. There are no waiver participants authorized to receive services in provider settings in which the provider is authorized to provide and/or perform Level III interventions.

DDS views the use of restraints as a measure of last resort, when other more positive interventions have failed. The Department established a restraint curriculum review committee in order to assure that only approved curricula are utilized by DDS providers. In order to receive approval as an acceptable curriculum, providers must demonstrate that the curriculum incorporates Positive Behavioral Supports as the framework for de-escalation techniques. The certification of the restraint curricula required that prone restraints were removed from the approved tool box and are no longer utilized. The restraint curricula are certified for three years and all providers must use an approved curriculum.

In all instances of restraint there must be evidence that the restraint is used only after the failure of less restrictive alternatives or that such alternatives would be ineffective under the circumstances. Restraints are not allowed as a convenience to staff or as punishment. As an additional safeguard, an intervention strategy must be developed if the behavior necessitating the restraint recurs more than once within a week or two times within a month. Emergency restraint may only be used as long as necessary, but for not more than one or two hours, depending upon who authorized the restraint.

Authorization must be obtained to continue utilizing the restraint. Under no circumstances, may any type of restraint be authorized on an "as needed" basis. There are two levels of authorization. First-the head of the provider, authorized physician, or a person designated to act on behalf of the head of the provider. Second- an authorized staff person appointed by the head of the provider and trained in applicable legal, clinical and safety criteria. The first status can authorize a restraint for two hour periods and the second may only authorize one hour periods.

Individuals must be observed at least every 15 minutes by a staff person specially trained to understand the individual's emotional and physical reactions to restraint. No restraint may be authorized for longer than six continuous hours, or eight hours in a day. Relief periods for individuals in restraint must occur for at least ten minutes of every two hours. Provision must be made for reasonable access to drinking water and bathrooms.
An individual may be given chemical restraint only when authorized by a physician. Such physician has to be either present or has had a telephone consultation with a licensed clinician who was present at the time of the emergency. Written documentation must be maintained as to any effects of the drug.

Renewal orders may be issued only if it is necessary to prevent the continuation or renewal of an emergency condition.

All restraints are required to be reported within 24 hours by the provider through the Department's web based incident reporting system known as the Home and Community Services Information System (HCSIS). The report documents the name of the individual subject to the restraint, the person issuing the initial restraint order, a description of any less restrictive alternatives utilized before the restraint was

ordered, the date and time, the name of the person applying the restraint, the nature of the restraint, a description of the emergency situation necessitating the use of restraint, the duration of the restraint.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Developmental Services has primary responsibility for overseeing and monitoring the use of restraints. Oversight occurs on the individual, provider and systems level. Within 24 hours of the restraint application, the individual subject to the restraint comments on the circumstances leading to the use of the restraint and on the manner of restraint used. Each month, the provider sends a copy of all restraint forms to the human rights committee which reviews all applicable data, considers all less restrictive alternatives to restraint and generally monitors the use of restraint by the provider or specific location. The Human Rights Coordinator for the agency then records the comments of the Human Rights Committee into the HCSIS database.
As part of the HCSIS database all restraints get reported to the service coordinator and human rights specialist who reviews the report and comments and follows up as necessary.
Standard management reports are generated quarterly by region and statewide. The reports detail patterns and trends with respect to numbers of restraints utilized, type of restraint, duration of restraint, and numbers of restraints per person. Information from these reports is utilized by area and regional directors to work with providers on programmatic and clinical interventions that might mitigate the use of restraints. The Director of the State Office of Human Rights reviews all data for purposes of analyzing patterns and trends. On an annual basis, data concerning restraint utilization is published in a DDS Quality Assurance Report and reviewed in depth by the Statewide quality council. The Director of the Office of Human Rights also publishes a quarterly report of "high utilizers", ie individuals who experience more than 10 restraints in a 3 month period. Follow up is conducted to determine what actions have been taken to decrease the use of restraints for these individuals. Finally, practices of provider agencies with respect to staff training, human rights committee review, and internal safeguards with respect to restraint utilization are reviewed as part of the licensure and certification process. This includes a review to assure that only an approved restraint training curriculum is being utilized.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDS has very stringent regulations and standards pertaining to the use of restrictive interventions, outlined in DDS regulations 115 CMR 5.14 The Department has a stated policy that all interventions designed to modify behavior must be the least restrictive and least intrusive. Interventions are subject to stringent reviews and safeguards. Interventions that are intrusive or restrictive are used only as a last resort and are subject to the highest level of oversight and monitoring.

At the time of submission of the Waiver renewal application, DDS is immersed in a major Departmental service improvement initiative to imbed the principles of Positive Behavioral Supports (PBS) into all aspects of its services and supports. This includes training, manuals and tools, and support to providers of service to implement the principles of PBS for all individuals the Department and its providers support. As part of this initiative, a number of immediate steps have already been taken, including but not limited to:
1) Revisions to all restraint curriculum (previously described) to embed positive behavioral supports as the major de-escalation framework strategy,
2) Promulgation of DDS regulations that prospectively eliminate the use of painful, aversive stimuli and deprivation procedures (previously defined as Level III interventions) as a contingent consequence to maladaptive procedures.
3) Assurance that DDS will not enroll any individual who receives Level III interventions in any of its HCBS Waiver programs.
4) DDS has also published notice of its intent to eliminate the use of contingent application of unpleasant sensory stimuli such as loud noises, bad tastes, bad odors, or other stimuli which elicit a startle response, and short delay of meal for a period not exceeding 30 minutes from the current description of allowable procedures in what is termed Level II interventions. These regulation should become final before the beginning of the Waiver Year beginning July 1, 2013.

As DDS moves forward with implementing PBS as the primary approach to supporting individuals, it plans to revise its current regulations, eliminating the current “levels” and replacing them with the more holistic and clinically accepted approach which PBS represents. The use of PBS is currently being piloted in a number of provider operated and DDS operated programs. Feedback from this pilot will be collected in July 2013. Training is also currently underway in the principles of PBS. Feedback from the pilot and these initial trainings will be analyzed during the summer of 2013 and will inform any necessary updates in the training curriculum and policies. Full implementation of PBS into all aspects of services and supports will remain an oingoing focus for the foreseeable future.

Current important safeguards in the DDS regulations pertaining to restrictive interventions continue to be in effect. All behavior plans regardless of the level must be in written form and part of the individual’s service plan. The plan must include a clear description of the behaviors to treat, specification of how the behavior will be measured, a functional analysis of the antecedents and consequences, the duration and type of intervention, other less restrictive alternatives that have been tried, the name of the treating clinician and a procedure for monitoring, evaluating and documenting the use of the intervention. The three levels of intervention currently utilized, but revised as described above include:

Level I- Positive reinforcement procedures and procedures which may also include aversive properties, neither of which pose no more than a minimal risk of physical or psychological harm and that do not involve significant physical exercise or physical enforcement to overcome the individual’s active resistance. Examples include differential reinforcement, satiation, tokens, corrective feedback and social disapproval, relaxation, restitution, ignoring, extinction, and time out not exceeding 15 minutes.
Level II- Any intervention otherwise classified as Level I where the procedure must be enforced over the person’s active resistance, or a time out with the individual in the room alone with a closed (but not locked) door for no longer than 15 minutes
Level III- As previously mentioned, as of October 1, 2011, this intervention has prospectively been eliminated. In addition, no individuals previously approved for the use of Level III interventions will be enrolled in any of the HCBS Waivers. There are no waiver providers who are authorized to use Level III interventions. There are no waiver participants authorized to receive services in provider settings in which the provider is authorized to provide and/or perform Level III interventions.

No plan may deny an individual adequate sleep, a nutritionally sound diet, adequate bedding, adequate access to bathroom facilities and adequate clothing. All Level II plans must be in written form and must be reviewed and approved prior to implementation by a qualified clinician. In addition, each plan must be reviewed by the provider’s human rights committee, (whose composition is prescribed in DDS regulations) and any concerns addressed prior to the implementation of the plan. Each plan is also reviewed by a physician to assure that the intervention is not medically contraindicated. Each plan is also reviewed by a peer review committee composed of three or more clinicians, at least one of whom

must be a licensed psychologist. Behavior plans may not be implemented unless informed consent has been obtained from either the individual or his/her guardian. All plans are subject to the procedural requirements concerning the ISP process and must be included in the ISP and subject to periodic review and appeal procedures.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Developmental Services has primary responsibility for the monitoring and oversight of restrictive interventions. In addition to the previously mentioned reviews by the ISP team, the human rights committee, and the peer review committee, the use of restrictive interventions is monitored in the following ways:
1) Service coordinators conduct bi- monthly site visits of homes providing 24 hour supports and quarterly visits of homes providing less than 24 hour supports. As part of the visit, service coordinators check to see whether behavior plans are being appropriately implemented if an individual has one.
2) Licensure and certification staff do an extensive review of interventions to assure that they have gone through all the necessary reviews, whether they are the least intrusive necessary to meet an individual's needs, whether they are being implemented according to requirements, whether staff has received appropriate training, whether documentation is maintained, and whether it has been reviewed periodically. Licensure staff will cite areas of concern in reports to providers if any of the above requirements have not been met. Follow up will be conducted by licensure and certification staff when a pattern or trend is noted.
3) Any instance of serious physical injury or death of a person who is also the subject of a Level II intervention is reported in the HCSIS database and immediately reported to the Commissioner or designee for review and follow up.
4) Aggregate data regarding the review, approval and monitoring of interventions collected during the licensure and certification process is included in the Department's Quality Assurance Reports and subject to review by the statewide quality council for the identification of patterns and trends.
5) Any individual, family member, provider staff or DDS employee may seek the guidance of the DDS Human Rights Specialist if he/she has any concerns regarding the plan or its implementation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

No use of seclusion is allowed by DDS regulations (115 CMR 5.11), thus, all such use is unauthorized. While extremely rare, the unauthorized use of seclusion must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to the state's Disabled Persons Protection Commission (DPPC), which screens all allegations of abuse, neglect and mistreatment. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion, may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission).

Case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and Program Development and Services Oversight Coordinators with information that is used to detect any use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The responsibility for monitoring medication regimens is a joint one between providers and DDS staff (specifically, service coordinators, area office nurses, and the ISP team). DDS has an electronic Health Care Record for all individuals that is maintained by providers and service coordinators and is updated for purposes of the annual ISP. Included in the health care record is a list of all medications the individual is taking. This allows for review of medications by the ISP team, as well as facilitating thorough communication of relevant medication information to primary health care providers. Provider agency nurses monitor the use of medication and side effects on an on-going basis. DDS area office nurses are available for consultation and support to providers when individuals are taking multiple medications. Direct support professionals are educated about the side effects of the specific medications individuals they are supporting are taking, and report any issues to the appropriate supervisory personnel.

Individuals prescribed behavior modifying medications have a written psychotropic medication treatment plan. The treatment plan is a portion of the Individual Service Plan and contains all the details of an individual's medication regimen. The treatment plan includes a description of the behavior to be modified, appropriate data concerning the target behavior or symptoms, common risks and side effects of the medication and a description of any clinical indications that might require termination of the therapy. The psychotropic drug treatment plan is completed by the prescribing physician, and signed by the individual or his/her guardian. It is reviewed and incorporated into the individual's ISP. Finally, any time an individual is subject to the use of anti-psychotic medication and is not legally competent to give consent, court approval must be obtained prior to administering the medication.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Service coordinators maintain regular contact with individuals on their caseload and monitor the health status of individuals they are supporting. In addition, through its Health Promotion and Coordination Initiative, DDS has created several processes that facilitate the exchange of information regarding health status and medication regimens between the DDS provider and the health care provider. DDS licensure and certification staff conduct an extensive review of the health care systems that providers have in place to assure coordination, communication and follow up with health care providers on key issues. They also review the level of training and knowledge that direct support professionals have about the health status and medications that the individual is taking. Aggregate data about health and medication status is reported in the DDS Annual Quality Assurance Report and reviewed by the regional and state quality councils.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state medication administration program (MAP) is implemented by the Department of Developmental Services and overseen by the Department of Public Health. Pertinent regulations are 115 CMR 5.15 as well as an extensive policy manual. The MAP program provides for the registration of locations where medication is administered, the requirements about storage and security of medications, the specific training and certification requirements for non-licensed staff, and documentation and record keeping requirements.

Community residential programs, day programs and short term site based respite services are required to obtain a site registration for the purpose of permitting medication administration by MAP certified staff and the storage of medications on site.

Direct support professionals, including licensed nurses working in positions that do not require a nursing license, must be certified in MAP in order to administer medications. MAP certification is valid for two years. Staff must be re-certified every two years. In order to be certified, staff must take part in an approved training curriculum not less than 16 hours, including classroom instruction, testing and a practicum. Trainers must be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets applicable requirements as a trainer. Individuals must pass a test in order to be certified to administer medications. The initial certification is done by the American Red Cross (ARC).

Re-certifications may be done by ARC or by an approved MAP trainer. MAP certified staff and providers must maintain proof of current certification. An individual's certification may be revoked for cause, after an informal hearing process. A record of revoked certifications is maintained by the American Red Cross.

Providers are required to adhere to a strict set of standards with respect to storage of medications, documentation of medication counts at the start and end of each shift, labeling of medications and documentation of medication administration for each individual.

Oversight of the medication administration program is conducted by nurses within provider programs as well as DDS MAP nurses and the Department of Public Health Clinical Review process.

Self-medication: An individual is determined to be self medicating when the medication is under the

complete control of the individual with no more than minimal assistance from program staff. The ability to self-medicate is determined in conjunction with the individual's ISP team as a result of an assessment process. If the individual is determined to be capable of learning to self-medicate, a teaching plan is developed and documented in the ISP. Once an individual is determined to be self-medicating, an oversight system is developed with built in review periods of at least every 3 months. An individual's ability to continue to self-medicate is reviewed in conjunction with the annual ISP process.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to file medication occurrence reports (MOR) to the Department of Developmental Services through the HCSIS web-based event reporting system. MOR's that involve any intervention by a health care provider are also reported to the State Department of Public Health. Pharmacy errors get reported to the Board of Registration in Pharmacy.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record a MOR in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted.

(c) Specify the types of medication errors that providers must *report* to the State:

same as above.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Developmental Services has primary responsibility of oversight of the Medication Administration Program. The Department of Public Health (DPH) also participates in the oversight responsibility. Providers are required to report all medication occurrences within 24 hours through the HCSIS system. The HCSIS MOR report details the person involved, the type of error, the medications involved, the consultant contacted, any medical interventions that were involved, what followed from the intervention and supervisory follow up action taken. Any MOR that involves medical intervention is also reported to the DPH and is defined as a "hot-line" call. All MOR's get reviewed by area MAP coordinators who are registered nurses. Follow-up occurs with providers on all MOR's. This may be accomplished through a phone conversation or a direct site visit, utilizing a clinical review checklist.

On an individual level, MOR's are reviewed by service coordinators and are part of an integrated review of all incidents that pertain to the individual. Program monitors and area directors review MOR information as part of the standard contract review process. Licensure and certification staff do a thorough review of both the medication storage and administration records as well as the certification of staff and their knowledge of the medications and their side effects.

Finally, on a systems level, all information regarding medication occurrences is aggregated and management reports are generated semi-annually. These reports detailing the number of medication occurrences including

the type and follow up action go to the legislature, Department of Public Health and other stakeholders. In addition, the HCSIS medication occurrence data base includes detailed information as to the factors contributing to a medication occurrence. Review of the management reports enable senior staff and Quality Councils to identify areas and strategies that may lead to a reduction in the number of medication occurrences, a target for service improvement. Information is then shared through training, publication of newsletters and advisories aimed at steps providers can take to reduce the number of medication occurrences. Data is also aggregated on an annual basis and incorporated into the DDS Annual Quality Assurance Report, which is reviewed by the regional and statewide quality councils for purposes of service improvement targets.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW a1. Number and rate of substantiated investigations by type (Number of substantiated investigations by type/number of total adults served and rate per 1000 adults)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW a2. Number of intakes screened in for investigation of abuse where the need for protective services were reviewed by the Area Office/Total number of intakes where a review for protective services were recommended by the senior investigator.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS Investigations database

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
HW a3. Percent of individuals receiving services subject to licensure and certification who know how to report abuse and/or neglect (Number of

individuals receiving services subject to licensure and certification who know how to report abuse and neglect/Number of individuals reviewed.)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence interval = 95% with 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi- annually

Performance Measure:
HW a4. Percent of providers, subject to licensure and certification, that report abuse/neglect as mandated. (Number of providers that report abuse/neglect as mandated by statute/number of providers reviewed.)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi- annually

Performance Measure:
HW a5. Percent of medication occurrences (Number of medication occurrences report/Number of medication doses administered.)

Data Source (Select one):
Medication administration data reports, logs
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi- annually

Performance Measure:
HW a6. Percent of deaths that are required to have a clinical review that received a clinical review. (Number of deaths that have a clinical review/Total number of deaths required to have a clinical review.)

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☑ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW a7. Percent of providers who conduct CORI's of prospective employees and take appropriate action when necessary. (Number of providers that conduct CORI's of prospective employees and take required action/Total number of providers reviewed.)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW b1. Percent of incident "trigger" reports that have had follow up action taken (Number of incidents that reach the "trigger" threshold for which action has been taken/Total number of incidents that reach the "trigger" threshold that were reviewed.)

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW b2. Percent of substantiated investigations where actions have been implemented. (Number of action plans implemented for substantiated investigations/ Total number of action plans written for substantiated investigations.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS Investigations database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW c1. Percent of providers that are in compliance with requirements concerning restrictive interventions (Number of providers that are in compliance with requirements concerning restrictive interventions/Number of providers reviewed by survey and certification with restrictive interventions.)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
HW c2. Percent of individuals with high utilization of restraints (10 or more per quarter) whose incidents of restraints have been reviewed by the Director of Office of Human Rights. (Number of individuals with high utilization of restraints that have been reviewed/Total number of individuals with high utilization of restraints.)

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCSIS Restraint Reporting database

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
HW d1. Percent of individuals who have had an annual physician visit in the last 15 months (Number of individuals with a documented physician visit in the past 15 months/ Number of individuals reviewed)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW d2. Percent of individuals who have had an annual dental visit in the past 15 months (Number of individuals with a documented dental visit in the past 15 months/Number of individuals reviewed)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW d3. Percent of physicians' orders and treatment protocols followed (Number of individuals for whom a treatment protocol/physicians' orders are followed/Number of individuals reviewed with treatment protocols/physicians' orders)

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

HW a1. All complaints filed with the Disabled Person Protection Commission are entered into the investigations database (Home and Community Services Information System, HCSIS). Data entered includes but is not limited to date, disposition, whether the investigation is substantiated and if so, what type of abuse or neglect was substantiated. Area and Regional Offices receive quarterly management reports which detail the number and rate of complaints for their area as well as for providers in their areas. Data is graphed so that area and regional managers can track patterns and trends. Areas and regions also run standard management reports detailing findings, date of issuance of action plans and action plan resolution target and completion dates for each individual complaint. Incident reports that are categorized as suspected mistreatment are required to be reviewed by the individual's service coordinator including the protective action steps that the provider has taken to assure that the individual is out of harm's way.

HW a2. All investigations screened in for investigation by DDS are reviewed by senior investigators to determine whether protective services are recommended. Recommendations are forwarded to the appropriate area office for review. The area office makes a determination of what, if any protective services are needed and contacts the involved provider.

HW a3., HW c1, HW d1-3. 100% of providers subject to licensure are reviewed through the licensure and certification process. Individuals who are reviewed as part of the sample are surveyed to determine whether they and their providers are trained and knowledgeable about reporting suspected abuse or neglect, have had

health care visits, have orders/protocols followed, as well as whether less restrictive alternatives have been reviewed prior to instituting restrictive interventions. Results are reported to the individual's service coordinator as well as being cited in the provider report.

HW a7. 100% of providers' CORI records are reviewed annually by a staff person in the Division of Investigations, whose sole responsibility it is to conduct the CORI audit. The review includes assuring that all employees have been subject to a CORI review, the information is documented, and that no one has been hired who has not gone through the CORI review. Providers receive a report detailing issues that emerge.

HW b1. A series of 10 "triggers" (i.e., a specific combination or number of incidents that may place an individual at risk) have been defined, including but not limited to multiple hospitalizations, 3 or more assaults, altercations or behavioral incidents within a 6 month period, 2 or more restraints within a month. Each Area Office and Service Coordinator receives a monthly report identifying any individual on their caseload who has reached any of the identified triggers. Regional Risk Managers receive a quarterly report of all individuals in their region who have reached the "trigger" thresholds.

HW c2. All restraints are reported on the HCSIS event management system. The reports give a thorough description of events necessitating the use of the restraint, the type of restraint, the amount of time the person was in the restraint and the individual's reaction to the restraint. The Director of the Office for Human Rights analyzes all data and generates a quarterly report, by region, that identifies individuals who have experienced a high rate of restraint in that particular quarter.

HW a5. All providers that have staff that utilize non-licensed certified staff to administer medications through the Medication Administration Program (MAP) are required to report any occurrence where a medication was administered at the wrong time, wrong person, wrong dose, or wrong route through the web-based Medication Occurrence System (MOR) in HCSIS. Any occurrence that results in any kind of medical intervention is automatically reported to the State Department of Public Health. All MOR's are reviewed by MAP coordinators (RN's) to determine whether appropriate action has been taken.

The measure is the total number of medication occurrences as compared to the total number of doses of medications administered statewide. The number of medication occurrences is divided by the total number of doses of medication administered, resulting in a rate/1000 medication doses.

HW a6. All deaths of individuals over the age of 18 eligible for services are reported on the HCSIS electronic data base within 24 hours. The investigations division reviews all reports for accuracy, including whether the death requires a full clinical review. All deaths required to have a full clinical review are forwarded to the Director of Health Services who oversees the clinical mortality review process. Certain deaths, according to specific established criteria are referred to the Statewide mortality review committee. Others are reviewed by Regional committees. The clinical review is a standardized process and format. Reviews can be closed on a regional level. The Director of Health Services does an audit of reviews done on a regional level to assure that they were closed appropriately. The Director also monitors and assures that 100% of the deaths for which a clinical review is required, have received a review.

HW b2. All substantiated complaints are required to have an action plan created. Action Plans are developed by local complaint resolution teams composed of DDS Area Office staff and citizen volunteers.

HW a4. Licensure and certification staff review staff logs, interview staff during the course of a survey to determine whether all issues that should have been reported, have been reported. This is one of the "critical indicators" whose compliance must be met in order for a provider to receive a license to operate.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Performance Measures HW a2.
Senior Investigators record and track all investigations where a review of protective services was recommended. Results of all reviews are entered into the investigation final checklist.

Performance Measures HW a3., HW c1, HW d1-3.

Issues identified must be corrected by the provider and subject to follow up by survey and certification staff.

Performance Measures HW a7.
Providers receive a report indicating the results of the audit and the specific follow up actions required depending on the nature of the findings. The audit staff maintains a tracking database to assure that all issues have been resolved.

Performance Measures HW b1.
Specific staff in each area office above the level of the service coordinator are required to follow up and make sure that appropriate action has been taken. Regional Risk Managers get quarterly reports which detail the individuals who have reached any of the thresholds as well as whether follow up action was taken. In this way, the Risk Managers assure that follow up action was taken.

Performance Measures HW a5.
Once an MOR has been reported, area nurses review actions taken by the provider. Area nurses follow up on all MOR's to minimize the chance of a recurrence. When necessary, area nurses may make on-site technical assistance visits to assure that all required MAP procedures and systems are in place. The Statewide Director of Health Services also conducts hearing regarding removal of MAP certification from staff to determine whether the staff person should retain their certification to administer medications.

Performance Measure HW a6.
The Director of Health Services will inform the Regional Teams if a death has not been reviewed as required. The Mortality Review Committee may require any additional information it feels necessary in order to assure a full and careful review. If there is any concern about the circumstances of the death, the case will be forwarded for a formal investigation. Feedback regarding the treatment course and events surrounding the death go back to the areas and providers. Information from the clinical review process informs the entire system with respect to strategies that may reduce the number of preventable deaths.

Performance Measure HW b2.
Area Offices are required to enter action plan information into the HCSIS Investigations database. This includes the date the plan was developed, the action required, and the date that the plan was implemented.

Performance Measure HW a4. Licensure and certification staff will follow up to assure that issues identified are corrected. Failure to meet and correct this standard will result in deferring the provider's license. If, upon Follow up, correction has not occurred, the provider will receive a recommendation to de-license.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services

that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Department's quality management and improvement system (QMIS) is robust and involves individuals in all levels of the Department as well as providers, self-advocates, families, and important stakeholders.

The QMIS system is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants as well as to use data and information to inform systemic quality improvement efforts. While it is a very robust system, the QMIS system continues to evolve and improve.

The Quality Improvement Strategy specified in this waiver is consistent with the QIS for MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver). With this amendment, DDS is proposing to consolidate reporting for all three Adult Waivers. Please see the explanation at the end of Appendix H.

The quality management and improvement system is designed and implemented based upon the following key principles:
1) The system creates a continuous loop of quality including the identification of issues, correction, follow-up, analysis of patterns of trends and service improvement activities.
2) Quality is imbedded in all activities of the Department and involves everyone.
3) The measurement of quality is based upon a set of outcomes in peoples' lives agreed upon with stakeholders.
4) The system involves active participation from individuals, families and other key stakeholders.
5) The system rigorously measures health, safety and human rights, and other quality of life domains
6) The system integrates data and information from a variety of different sources.
7) The system collects, aggregates and analyzes data to identify patterns and trends to inform service improvement activities.
8) Service improvement targets are tracked to allow for measurement of progress over time.

Quality is approached from three perspectives: the individual, the provider and the system. On each tier, the focus is on discovery of issues, remediation and service improvement. Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to inform overall system performance efforts.

Systems level improvement efforts are organizationally structured to occur on essentially two levels – the regional level and the statewide level. DDS is divided into 23 separate area offices, each overseen by an Area Director. In turn, there are four Regional Offices overseen by a Regional Director, under whose direct supervision the Area Directors function. It is ultimately the Regional Directors, who report directly to the Deputy Commissioner, who are accountable for assuring that identified service improvement efforts are implemented and reviewed. Area Offices work most closely with the individuals the Department serves and their providers through the service planning and oversight processes.

On a statewide level, the Office of Quality Management maintains overall responsibility for designing and overseeing the Department's QMIS and assuring that appropriate data is collected, disseminated, reviewed and service improvement targets established for both waiver and non-waiver DDS clients. The Assistant Commissioner for Quality Management reports in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division. The Waiver Unit functions within the Operational Services Division. Its primary function is to oversee the implementation of the various components of the

Waiver. In addition, specific staff in the Central Office/DDS function as "subject leaders" and take responsibility for discrete data sets and their analyses. For example, the Director of Health Services is responsible for reviewing and analyzing all data relating to medication occurrences, health care records and deaths, the Director of Human Rights reviews all restraint reports and the Director of Risk Management reviews data regarding risk management plans.

Processes for trending, prioritizing and implementing system improvements:

DDS has a variety of databases that enable it to collect information on important outcomes related to the six assurances under the waiver. These include the Meditech system, which collects data on level of care, plans of care, enrollment, expenditures for waiver participants and risk management plans; the Home and Community Services Information System (HCSIS) which collects information regarding the development and oversight of Individual Service Plans, incidents, restraints, medication occurrences, investigations, health status, and deaths; and the Survey and Certification database, which collects information on both outcomes for individuals served by the Department as well as provider performance.

In addition to reports previously mentioned in the other appendices, there are a number of additional ways in which data is aggregated, reported, and reviewed that specifically facilitate the analysis of patterns and trends and the development of service improvement targets. As a starting point, the Department has two major standards groups that are responsible for overseeing the quality and integrity of the data the Department collects. The groups are composed of internal and external users of the two primary data systems (Meditech and the Home and Community Services Information System, HCSIS). These groups function to continually review and agree upon the business processes as well as the definitions and interpretations that guide the system in order to ensure data integrity and consistency.

Up until a few years ago the Department published an Annual Quality Assurance Report that derived data from all of the different databases maintained. Based on input received from the Quality Council and other stakeholders using the report, the format was changed. In lieu of one report detailing all outcomes reported on, DDS moved to QA Reports that focus on specific subject areas, e.g. rights, health, safety. The reports present information in a user-friendly manner, relying on easy to use graphs and arrows delineating both positive and negative change. The report compares outcomes year to year and allows for a clear analysis of patterns and trends over time. Statewide Quality Council has the specific responsibility to review this report and other data and make recommendations to the Commissioner and other DDS staff for service improvement targets. The Quality Council is comprised of DDS staff, self-advocates, family members, and providers, and is supported by staff from the Center for Developmental Disabilities Evaluation and Research (CDDER) from the University of Massachusetts Medical School. The Council’s sole function is to review and analyze the different analyses and reports that are generated with respect to systemic performance, to make recommendations for service improvement and to track progress towards achievement of service improvement targets. Since DDS submitted the initial waiver applications, the composition of the Councils has been modified. In lieu of four separate Regional Councils there is now one Statewide Council that draws representation from each of the former regional councils.

In addition to the Quality Councils, there is a Statewide Incident Review Committee (SIRC), composed of staff from investigations, human rights, survey and certification, risk management, health services, and operations. The committee reviews the analyses that are generated from HCSIS. With the research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research, aggregate reports analyzing specific incident types are generated. The reports are reviewed by the committee and form the basis of service improvement targets. Reports generated from the risk management committee are also reviewed by the Quality Council and mutually agreed upon service improvement targets are developed.

Since March 2008, area, region and provider specific aggregate data on incidents began to be disseminated quarterly (for frequently occurring incidents) and annually (for less frequently occurring incidents). These reports show data on incidents by both number and rate that enable comparison between an area to a region to the state. Data from month to month is shown and fluctuations below and above 25% are noted. Field staff (i.e. Area Office staff) analyze patterns and trends in their respective locations. In addition to individual incident reports, Area Offices receive monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review on an area level. These reports enable areas and regions to identify patterns and trends with respect to particular individuals they support, and to “connect the

dots" between different incidents. Areas review the reports and enter follow up notes to assure that individuals who may be at risk have been identified and followed up on. As part of the on-going quality assurance process, Regional Risk Managers do a quarterly review of a random sample of individuals who have reached the "trigger" threshold. The review looks into whether follow up actions were taken and whether the actions were consistent with the issues identified.

The Department also publishes an independently developed Annual Mortality Report by CDDER that details the numbers of deaths, the age, gender, and residential status of individuals, and the causes of death. The report is reviewed by the Quality Council as well as the Regional and Statewide Mortality Review Committees. Data from this report also informs the development of quality improvement activities. In addition to the abovementioned reports, DDS publishes a "Quality is No Accident" (QINA) Brief. The QINA briefs focus in on one particular area per publication and combine data derived from the Incident Management System and other data sources, with practical information regarding risk prevention and mitigation activities. Examples of subjects covered in the past include healthy sexuality, oral health care, preventive health care, Alzheimer's/dementia, and missing persons.

As mentioned earlier, each "subject leader", e.g., Director of Health Services, Director of Human Rights, is responsible for the detailed review and analysis of data for their specific area of responsibility. Data is typically reviewed on a monthly basis and patterns and trends identified. Subject leaders will then work directly with field staff and others on areas that have been identified for improvement.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: Semi-annually

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Office of Quality Management and senior management staff of the Department have primary responsibility for monitoring the effectiveness of system design changes. Implementation of strategies to meet service improvement targets can occur on a variety of levels depending upon the nature of the target. As an example, the Quality Council established an increase in real employment for individuals in the Department as a statewide service improvement target. Regional employment solutions teams were established to develop strategies. Providers were required to submit specific plans and target numbers for increasing individual employment options. This was followed by the development and publication of the "Blueprint for Employment," which called for the transformation of all sheltered workshop settings. Progress in this area shows that by June 2016, all remaining workshops will have been closed.

Reviews of the effectiveness of other service improvement targets are also conducted by the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. As an independent research and policy support to the Department, CDDER has conducted several formative and summative evaluations of specific service improvement initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target. An

example of CDDER's role was its evaluation of the Department's Health Promotion and Coordination Initiative.

More targeted service improvement efforts may involve a discrete number of individuals who have specific responsibility in the subject of the effort. For example, the Director of the Office of Human Rights disseminates quarterly reports to Regional Directors regarding the use of restraints. A service improvement target to reduce the number of restraints for "high utilizers" was identified and worked on with the specific areas and providers involved. Change was tracked by the Office of Human Rights and noted.

The Department shares most statewide quality assurance and service improvement data with a host of internal and external stakeholders. The Quality Assurance Reports the Annual Mortality Report, analyses of HCSIS incident data, and provider licensure/certification reports are all posted on the Department's web site as well as distributed in hard copy. Individuals, families and providers are also active members of the Statewide Quality Council, area Citizen Advisory Boards, and statewide committees. In this capacity, all quality improvement data and reports are shared, discussed and reviewed with them.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The effectiveness of the Quality Management system is reviewed through the following mechanisms:

1) The Office of Quality Management (OQM) has primary day to day responsibility for assuring that the Department has an effective and robust quality management system in place for both HCBS waiver and non-waiver services. OQM works with internal and external stakeholders and makes recommendations regarding enhancements to the QMIS system on an on-going basis.
2) As part of its responsibility, the Statewide Quality Council reviews outcomes and indicators measured and make recommendations to the Department regarding the need to add, change or amend the quality indicators. The council, because of its broad representation from internal and external stakeholders is in a unique position to reflect upon the Department's QMS system.
3) The Department works with the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. CDDER has and will continue to assist the Department to evaluate the effectiveness of its QMS system and to make recommendations for improvements.

As part of the evaluation of the Quality Improvement Strategy that OOM and DDS engaged in during this amendment process, we analyzed reporting across several waivers. As determined by that evaluation process and as noted above, we are consolidating the reporting for this waiver together with MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver). Our evaluation determined that because these waivers utilize the same quality management and improvement system, that is, they are monitored in the same way, and discovery, remediation and improvement activities are the same, these waivers meet the CMS conditions for a consolidated evidence report. Specifically, the following conditions are present:

1. The design of these waivers is very similar as determined by the similarity in participant services (very similar), participant safeguards (the same) and quality management (the same);
2. The quality management approach is the same across these three waivers including:
a. methodology for discovering information with the same HCSIS system and sample selection,
b. remediation methods,
c. pattern/trend analysis process, and
d. all of the same performance indicators;
3. The provider network is the same; and
4. Provider oversight is the same.

For performance measures based on sampling, the sample size will be based on a simple random sample of the combined populations with a confidence level of .95.

As part of our intent to consolidate evidence reports, OOM and DDS will transition from the current approved performance measures to proposed amended performance measures during Waiver Year 3 (2015/2016).

This waiver, MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver) operate on the same waiver cycles and will be reported on with the same frequency.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) 808 CMR 1.00 requires organizations entering into a contract with the Commonwealth to perform an independent audit and annually submit a Uniform Financial Statement and Independent Auditor's Report to the Executive Office of Administrations and Finance's Operational Services Division. These are reviewed by the Department's contracts office annually (for existing/current providers) and before executing a contract (for new providers).

(b) The integrity of the provider billing data for Medicaid payment of waiver services is managed by the Department of Developmental Services' (Department) Meditech operating and claims production system and the Massachusetts Medicaid Management Information System (MMIS). Meditech contains waiver service delivery information, demographic information, the level of care (LOC), the Plan of Care (POC/ISP), the Medicaid category of assistance (CAT) and assigned service coordinator information for each waiver participant. DDS has access to all data within Meditech and various checks and balances as well as system edits are in place to ensure appropriate waiver service claims are submitted to MMIS. MMIS validates waiver service rates and MassHealth eligibility for dates of services claimed as a condition of payment.

(c) The Commonwealth also conducts an annual Single State Audit that includes sampling from the Department's waiver(s) service claims. The Audit reviews contract and Quality Enhancement certification documents; Plans of Care, Choice and Level of Care documents; service delivery data, claims and payment records. As necessary the Department can establish an audit trail including the point of service, date of service, rate development, provider payment status, claim status, and any other waiver related financial information. The Office of the State Auditor bids a contract with an independent auditor to conduct the Single State Audit.

Individual waiver participants are coded as such in the Department of Developmental Services' database and claims checks assure that (1) Level of Care, Plan of Care, Medicaid Eligibility, and Service Coordinator are in place prior to a claim being processed and (2) claims are processed only for waiver eligible individuals for waiver eligible services provided by waiver eligible providers.

The State then processes each claim interfacing with edits ensuring that the individuals are in a waiver eligible Medicaid category of assistance and that the services claimed are waiver eligible services.

Attendance data is submitted through a web-based Electronic Service Delivery Report System (E-SDR) and the Department's Regional Office staff review and confirm dates of service information for all individuals. This approved data provides the documentation necessary for payment to the provider and for development of a claim for the Medicaid Agency. Original paper source documentation of service delivery is maintained.

Once the Regional staff have approved all service delivery entries, the data is matched with rates and with individual waiver eligibility criteria and are submitted by electronic submissions in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS). Claim checks are part of the Department's electronic claims processing system to assure that all waiver assurances are met prior to processing. If an individual's Medicaid status has changed, when a submission is processed through MMIS any claim for dates of services where the individual was not Medicaid eligible is automatically denied.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA a1. Services are billed in accordance with the plan of care. The percentage of claims submitted to and paid by MMIS will be monitored and reported by the Department. (Numerator: Approved and paid MMIS claims. Denominator: Total service claims submitted.)

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: UMASS Revenue Unit	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: UMASS Revenue Unit	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
FA a2. Services are billed in accordance with the plan of care. (The percentage of claims for services with the Fiscal Intermediary Service that are filed appropriately. Numerator: Approved claims filed with the Fiscal Intermediary Service. Denominator: Total number of claims filed with the Fiscal Intermediary Service.)

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: Fiscal Management Service	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: Fiscal Management Service	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA b1. Services are coded and paid for in accordance with the reimbursement methodology specified in the waiver application. (Numerator: number of services

with rates derived from and consistent with rate regulations. Denominator: Number of services for which claims were submitted.)

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
FA a1. Claims are submitted monthly to MMIS based on client eligibility, service delivery information and claim edit checks within Meditech to ensure that all services for eligible waiver clients meet the appropriate criteria for Federal Financial Participation, including items such as eligible POC, LOC, and CAT. MMIS further validates these claims based on dates of services, payment, rates and MassHealth eligibility prior to payment. A monthly remittance report is generated by MMIS detailing claims paid and denied along with appropriate denial codes. Remittance reports are reviewed and researched by the UMASS Public Provider Reimbursement (PPR) department and service claims are resubmitted as appropriate. PPR also reviews service claims that do not meet the initial criteria established in Meditech and works with the Department to identify problems and/or solutions to improving documentation or follow-up of waiver criteria to capture all eligible service claims.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
FA a1. Individual problems discovered as a result of the review of remittance advises or system waiver criteria are addressed in a Department internal working group consisting of program staff, financial staff, system staff, and PPR staff that meets regularly to report and monitor any problems and recommend changes to Meditech or internal procedures to enhance the generation of eligible waiver service claims. Any significant problems that impact payment processing through MMIS are also reported to the Executive Office of Health and Human Services.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Waiver service rates are developed based on service expenditures and utilization. The rate methodology is uniform for all waiver services and based on cost. All costs that are not eligible for federal financial participation, such as room and board, are excluded from the rate computation. The Division of Health Care Finance and Policy establishes the rates for all waiver services that are the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. The rates are approved at a public meeting of the Division of Health Care Finance and Policy. M.G.L.c. 118g s.7 governs the rate approval responsibilities of the Division of Health Care Finance and Policy. Upon rate approval, rates are entered into the Meditech system and MMIS.

DDS negotiates contracts with service providers and pays providers at the negotiated rate of payment. Claims for FFP are submitted at a provisional rate equal to the average of the contract rates for each service. At the end of each waiver year the a final rate is established for each service based on the total costs for and utilization of each waiver service. Claims are then adjusted to account for any differences between the provisional and final rate.

Self-directed services are paid through the Fiscal Management Service at rates within an established range of payment. Participants may determine staff wages within the established range of payment. The minimum that may be paid is the state's minimum wage, while the maximum is set as the agency provider rate for the service to be provided. These limits apply to wages for all participant directed services.

By regulation, rates established by DHCFP require public meetings and include comments from both stakeholders and the general public. As part of the rate setting process prior to public hearing, DHCFP organizes provider technical assistance groups to provide feedback and information about the elements of the rate.

Information about payment rates will be available on the DDS website and is shared with waiver participants at the time of the service planning meeting.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

There are two types of billings for waiver services: Service Provider billings and billings for Self-Directed services through the Fiscal Management Service.

Provider billings: Attendance data is submitted by service providers through the Enterprise Invoice Management System (EIM), a web based electronic service delivery system, and DDS's Regional staff review and confirm dates of service information for all individuals.

The data is matched with rates and individual waiver eligibility criteria and submitted by electronic submission in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS).

When a submission is processed through MMIS, any claim for dates of service where the individual was not Medicaid eligible is automatically denied.

For Self-Directed Services, Public Partnerships, Limited (PPL), the Financial Management Service, submits service data to DDS. Provider billings flow from a provider to the Financial Management Service which provides financial management services; the Financial Management Service makes payment of invoices for waiver goods and services that have been requested by the participant and are included in the participant's budget and authorized in the service plan. The FMS is then responsible for submitting service data through the DDS electronic service delivery reporting system. Individuals are coded as waiver participants in the DDS Meditech database and claims checks assure that the level of Care, Plan of Care, Medicaid eligibility and Service Coordinator are in place prior to a claim being processed; claims are processed only for waiver eligible individuals for waiver eligible services provided by waiver eligible providers.

Components:
Original source documentation is maintained in hard copy format by service providers, the Financial Management Service and in electronic form by DDS. Consumer specific information is on file at DDS Area Offices and in the DDS Meditech database. DDS uses the Meditech system to support various operational and policy/planning functions. As outlined in Appendix I-1, the Meditech database contains waiver service delivery information, demographic information, the level of care, plan of care, the Medicaid category of assistance and assigned service coordinator information for each waiver participant. Meditech is the case management data system and also includes all assessment data and case management progress notes.

Claim checks are part of the DDS electronic claims processing system to assure that all waiver assurances are met prior to processing a claim for FFP.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

○ **No. State or local government agencies do not certify expenditures for waiver services.**

◉ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

DDS certifies public expenditures for waiver services. Expenditures are certified annually utilizing cost report data. Staff from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School Center for Health Care Financing review cost reports and identify allowable and disallowable costs (such as room and board). Payments are made to waiver providers contracted through DDS. These providers retain 100% of the payment.

Expenditures for waiver services are funded from annual legislative appropriations to the Department of Developmental Services. Claims for waiver services are adjudicated at approved rates through the state's approved MMIS system. The approved rates are set by the Division of Health Care Finance and Policy and are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

As described above, the Department's Electronic Service Delivery system and Meditech systems and MMIS provide ample checks and balances to assure that FFP is claimed on the CMS-64 only when an individual is eligible for Medicaid waiver payment on the date of service rendered, included in the participant's approved service plan and for the services provided. The service delivery reporting system reconciles provider payment to dates of service reporting and Meditech edits claims to ensure only service claims that meet all waiver criteria are submitted for payment processing to MMIS. MMIS validates all waiver service claims for dates of services and Medicaid eligibility prior to payment which is then reported as FFP in the CMS-64.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers may receive payment directly from the Medicaid agency. Information on how Providers may bill Medicaid directly will be posted on the DDS website and with the procurement materials on the Commonwealth Procurement Access and Solicitation Site (Comm-PASS).

For Self-Directed Services, billings will flow from a provider to Public Partnerships, Limited (PPL), the FMS providing financial management services. The FMS will be responsible for submitting service data through the Department of Developmental Services' (the Department) electronic service delivery reporting system. Individuals are coded as waiver participants in the Department's Meditech database and claims checks assure that the Level of Care, Choice, Plan of Care, Medicaid eligibility and Service Coordinator are in place prior to a claim being processed and that claims are processed only for waiver eligible individuals for waiver eligible services provided by waiver eligible providers; and that claims are processed only for services that are included in a participant's budget and authorized in the service plan. The above data is matched with rates and individual waiver eligibility criteria and submitted by electronic submission in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS). When a submission is processed through MMIS, any claim for dates of service where the individual was not Medicaid eligible is automatically denied.

Components:
Original source documentation is maintained in hard copy format by service providers, the Financial Management Service and in electronic form by the Department. Consumer specific information is on file at the Department's Area Offices and in the Department's database. Service providers submit information through the Enterprise Invoice Management System (EIM), a web based electronic service delivery system. Claim checks are part of the Department's electronic claims production system to assure that all waiver assurances are met prior to processing a claim for FFP.

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Department of Developmental Services providers furnish residential habilitation, assistive technology, behavioral supports and consultation, individual supported employment, group supported employment, community based day supports, center based day supports and respite.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments**

(including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver;

(e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) The Department of Developmental Services is designated as the Organized Health Care Delivery System for this home and community based waiver. It provides at least one Medicaid service and arranges for others.
(b) The FMS and the Department maintain a list of qualified direct providers available throughout the state. A qualified direct provider may enroll with the FMS or the Department at any time.
(c) Participants have free choice of qualified providers. Any willing and qualified provider has the opportunity to enroll as a provider of waiver services. DDS posts on its website the requirements and procedures for potential providers to qualify to deliver services. The qualifying system is open and continuous to allow potential providers to enroll as they become ready to deliver services to participants. Newly qualified direct providers can be added to the list maintained by the FMS or the Department from time to time A list of qualified providers is also maintained on the DDS website to allow participants ready access to this information. Participants are also assisted in accessing this information through their Service Coordinator.
(d) The FMS or the Department oversees and monitors the contracts for providers that furnish services under the waiver. The Department or the FMS will review direct provider qualifications based on the qualifications in Appendix C and Appendix H.
(e) OHCDS contracts with direct care providers will be governed by the provisions of an interagency service agreement between the Department and EOHHS.
(f) Financial accountability is assured as described in Appendix I-1. The Commonwealth conducts an annual Single State Audit that includes sampling from the Department's waiver(s) service claims. The Audit reviews contract and Quality Enhancement certification documents; Plans of Care, Choice and Level of Care documents; service delivery data, claims and payment records. As necessary the Department can establish an audit trail including the point of service, date of service, rate development, provider payment status, claim status, and any other waiver related financial information. The Office of the State Auditor bids a contract with an independent auditor to conduct the Single State Audit.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Annual legislative appropriation to the Department of Developmental Services provides the non-federal share which is expended directly by DDS as CPEs. The Department of Developmental Services directly makes expenditures from its appropriation and Federal Financial Participation (FFP) is returned to the State General Fund. Neither the Medicaid agency nor DDS retain any FFP. All FFP is returned to the State General Fund.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As Specified in Appendix C the State furnishes Waiver Services in residential settings other than in the personal home of the individual. The Department of Developmental Services provides residential habilitation and stabilization waiver services both in state-operated residences and in vendor-operated residences. The Department maintains a database to capture and document all costs associated with residential habilitation and stabilization vendor contracts. The formula embedded in this data base takes the total cost of the contract, less non-reimbursable costs (examples: room and board/meals and occupancy, as well as administrative reductions, stipends, non-meals, occupancy and utilities offsets). These waiver service costs, less the non-reimbursable costs, are divided by the total number of units available for that specific contract to derive a specific waiver rate. The use of this database allows DDS to identify and ensure actual room and board costs, as well as other non-reimbursable costs, are removed prior to the costs used to calculate the final waiver rate. Similarly, the costs of the state-operated residential habilitation and stabilization services are calculated and the non-reimbursable costs are excluded in order to derive waiver rate state-operated services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ( ) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- (●) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

The Department reimburses for both room and board. The Department, as the provider, reimburses the waiver participant for the cost of additional living space and the increased utility costs to afford the live-in caregiver a private bedroom. The reimbursement for the increased rental costs will be based on the DDS Housing Guidelines established by the Department at 150% of the median rental costs per HUD region.. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid Services. The reimbursement for food costs will be based on the USDA Moderate Food Plan cost averages.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	114056.35	24834.48	138890.83	261008.21	1611.74	262619.95	123729.12
2	113982.53	25604.35	139586.88	269099.47	1661.71	270761.18	131174.30
3	113697.65	26398.08	140095.73	277441.55	1713.22	279154.77	139059.04
4	117214.51	27216.42	144430.93	286042.24	1766.33	287808.57	143377.64
5	120725.30	28060.13	148785.43	294909.55	1821.09	296730.64	147945.21

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	8797		8797
Year 2	8970		8970
Year 3	9118		9118
Year 4	9218		9218
Year 5	9218		9218

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

All estimates are derived from the 2011 CMS-372 report for the Adult Residential Waiver # MA.0827.R00.01 for Waiver Year 1 (7/1/10 to 6/30/11) unless otherwise documented.

The Average Length of Stay (ALOS) of 352 is the actual ALOS reported on the 2011 CMS-372 report.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Number of Users: Estimates for the number of users were based on 2011 372 data for each service in the Adult Residential Waiver #MA.0827.R00.01 except as noted below. The projected number of unduplicated participants each year was based on Department of Developmental Services (DDS) experience with this waiver to date and expected growth. Current enrollment in the Residential Waiver is 8,138 participants. The renewal allows for modest growth in the number of participants from this current enrollment level. The estimated number of users for the following services was based on DDS's Meditech data on participants in the Adult Residential Waiver in SFY 2012: Respite, Assistive Technology, Occupational Therapy, Family Training, Physical Therapy, Speech Therapy, Transportation (mile), and Transportation (transit pass). Based on DDS' experience with the waiver population to date, and accounting for utilization of similar state-funded services and planned programmatic changes in future waiver years, the number of users was projected for the following services: Residential Habilitation, Behavioral Supports and Consultation, 24-Hour Self Directed Home Sharing Support, Transitional Assistance Services, Specialized Medical Equipment and Supplies, Live-In Caregiver, Individualized Home Supports, Chore, Vehicle Modification and Adult Companion.

Average Units per User: The average units per user were based on 2011 372 data for each service in the Adult Residential Waiver # MA.0827.R00.01 except as noted below. DDS projected the average units per user for the following services based on experience to date with similar state-funded services: Respite, Behavioral Supports and Consultation, Occupational Therapy, Family Training, Physical Therapy, Speech

Therapy, Transportation (mile) and Chore. The average units per user for Transportation (transit pass), Live-In Caregiver, and Individualized Home Supports were based on experience to date with similar state-funded services. The average units per user for Assistive Technology, Home Modifications and Adaptations, Individual Goods and Services, Transitional Assistance Services, Specialized Medical Equipment and Supplies, and Vehicle Modification is 1, reflecting "Item" as the unit of measure, based on DDS experience.

Average Cost per Unit: The average cost per unit was based on FY 2012 rates for the Adult Residential Waiver # MA.0827.R00.01 approved by the Commonwealth's rate-setting agency, the Division of Health Care Finance and Policy (DHCFP) except where otherwise noted. In the case of services with multiple rate tiers, such as Residential Habilitation, a weighted average was calculated across all rates for the service to estimate a base rate. The average cost per unit for 24-Hour Self Directed Home Sharing Support was based on DDS experience with similar state-funded services. For those services with a Unit of "Item," average costs per unit were based on the DDS experience with similar state-funded services.

Trend: The rates described above were used for Waiver Year 1 and trended annually using the Consumer Price Index of 3.1% for subsequent years. Services such as Assistive Technology, Home Modifications, Individual Goods and Services, Transitional Assistance Services, Specialized Medical Equipment and Supplies, and Vehicle Modification were not trended annually as these services are not rate based and prices are not expected to increase annually, based on DDS's experience.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' costs are based on SFY 2011 utilization of all other Medicaid services (D') by participants in waiver #0827.R00.01 as reported on the 2011 CMS-372 report.

SFY 2011 costs were trended forward annually by the Consumer Price Index (3.1%) to estimate Factor D' for SFY 2014 (Waiver Year 1), as well as for subsequent waiver years.

As Factor D' costs are based on FY 2011 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore, no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G costs are based on the facility component (G) costs for SFY 2011 as reported on the 2011 CMS-372 report for Waiver #0827.R00.01.
Factor G on the 2011 CMS-372 was derived from the cost per member for MassHealth members who resided in an ICF-ID in SFY 2011. Actual costs were included for all members who were in a facility for at least 180 continuous days (a long stay), although only the claims that occurred during SFY 2011 for the period of facility stays were included in the set. The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable.

SFY 2011 costs were trended forward annually by the Consumer Price Index (3.1%) to estimate Factor G for SFY 2014 (Waiver Year 1), as well as for subsequent waiver years.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' costs are based on the utilization of all Medicaid services (G') other than ICF-ID services in SFY 2011 for MassHealth members residing in an ICF-ID for a long stay as reported on the CMS-372 report for Waiver #0827.R00.01. The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable.

SFY 2011 costs were trended forward annually by Consumer Price Index (3.1%) to estimate Factor G' for SFY 2014 (Waiver Year 1), as well as for subsequent waiver years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Center Based Day Supports	
Group Supported Employment	
Individualized Home Supports	
Live-In Caregiver	
Residential Habilitation	
Respite	
Day Habilitation Supplement	
24-Hour Self Directed Home Sharing Support	
Adult Companion	
Assistive Technology	
Behavioral Supports and Consultation	
Chore	
Community Based Day Supports	
Family Training	
Home Modifications and Adaptations	
Individual Goods and Services	
Individual Supported Employment	
Individualized Day Supports	
Occupational Therapy	
Peer Support	
Physical Therapy	
Specialized Medical Equipment and Supplies	
Speech Therapy	
Stabilization	
Transitional Assistance Services	
Transportation	
Vehicle Modification	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports Total:						22904175.36
			GRAND TOTAL:			1003353679.91
			Total Estimated Unduplicated Participants:			8797
			Factor D (Divide total by number of participants):			114056.35
			Average Length of Stay on the Waiver:			352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports - 15 minutes	15 minutes	1408	3901.00	4.17	**22904175.36**	
Group Supported Employment Total:						**3157726.00**
Group Supported Employment - 15 minutes	15 minutes	440	2353.00	3.05	**3157726.00**	
Individualized Home Supports Total:						**5214944.00**
Individualized Home Supports - 15 minutes	15 minutes	100	6944.00	7.51	**5214944.00**	
Live-In Caregiver Total:						**683330.56**
Live-In Caregiver - per diem	per diem	88	352.00	22.06	**683330.56**	
Residential Habilitation Total:						**914438869.11**
Residential Habilitation - per diem	per diem	8521	333.00	322.27	**914438869.11**	
Respite Total:						**357060.88**
Respite - 15 minutes	15 minutes	88	401.00	4.07	**143622.16**	
Respite - per diem	per diem	88	12.00	202.12	**213438.72**	
Day Habilitation Supplement Total:						**12547254.72**
Day Habilitation Supplement - 15 minutes	15 minutes	1232	3561.00	2.86	**12547254.72**	
24-Hour Self Directed Home Sharing Support Total:						**2543960.32**
24-Hour Self Directed Home Sharing Support -Level 1 - per diem	per diem	4	352.00	37.33	**52560.64**	
24-Hour Self Directed Home Sharing Support -Level 2 - per diem	per diem	14	352.00	52.66	**259508.48**	
24-Hour Self Directed Home Sharing Support -Level 3 - per diem	per diem	70	352.00	90.58	**2231891.20**	
Adult Companion Total:						**868227.36**
Adult Companion - 15 minutes	15 minutes	176	973.00	5.07	**868227.36**	
Assistive Technology Total:						**70400.00**
Assistive Technology - item	item	88	1.00	800.00	**70400.00**	
Behavioral Supports and Consultation Total:						**1841320.80**
Behavioral Supports and Conusultation - 15 minutes	15 minutes	440	201.00	20.82	**1841320.80**	

GRAND TOTAL:	**1003353679.91**
Total Estimated Unduplicated Participants:	**8797**
Factor D (Divide total by number of participants):	**114056.35**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Total:						**104079.36**
Chore - 15 minutes	15 minutes	88	168.00	7.04	**104079.36**	
Community Based Day Supports Total:						**18609642.48**
Community Based Day Supports - 15 minutes	15 minutes	1144	3901.00	4.17	**18609642.48**	
Family Training Total:						**128810.88**
Family Training - 15 minutes	15 minutes	88	228.00	6.42	**128810.88**	
Home Modifications and Adaptations Total:						**158400.00**
Home Modifications and Adaptations - item	item	88	1.00	1800.00	**158400.00**	
Individual Goods and Services Total:						**88000.00**
Individual Goods and Services - item	item	88	1.00	1000.00	**88000.00**	
Individual Supported Employment Total:						**9602345.28**
Individual Supported Employment - 15 minutes	15 minutes	528	3026.00	6.01	**9602345.28**	
Individualized Day Supports Total:						**1354143.12**
Individualized Day Supports - 15 minutes	15 minutes	88	2049.00	7.51	**1354143.12**	
Occupational Therapy Total:						**87718.40**
Occupational Therapy - visit	visit	88	14.00	71.20	**87718.40**	
Peer Support Total:						**24967.36**
Peer Support - 15 minutes	15 minutes	88	82.00	3.46	**24967.36**	
Physical Therapy Total:						**84145.60**
Physical Therapy - visit	visit	88	14.00	68.30	**84145.60**	
Specialized Medical Equipment and Supplies Total:						**105600.00**
Specialized Medical Equipment and Supplies - item	item	88	1.00	1200.00	**105600.00**	
Speech Therapy Total:						**89788.16**
Speech Therapy - visit	visit	88	14.00	72.88	**89788.16**	
Stabilization Total:						**1922141.76**

GRAND TOTAL:	**1003353679.91**
Total Estimated Unduplicated Participants:	**8797**
Factor D (Divide total by number of participants):	**114056.35**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Stabilization - per diem	per diem	88	84.00	260.03	1922141.76	
Transitional Assistance Services Total:						44000.00
Transitional Assistance Services - item	item	88	1.00	500.00	44000.00	
Transportation Total:						6146628.40
Transportation - one-way trip	one-way trip	880	376.00	18.10	5988928.00	
Transportation - mile	mile	88	455.00	0.51	20420.40	
Transportation - transit pass	transit pass	88	12.00	130.00	137280.00	
Vehicle Modification Total:						176000.00
Vehicle Modification - item	item	88	1.00	2000.00	176000.00	
				GRAND TOTAL:		1003353679.91
				Total Estimated Unduplicated Participants:		8797
				Factor D (Divide total by number of participants):		114056.35
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports Total:						24071120.50
Center Based Day Supports - 15 minutes	15 minutes	1435	3901.00	4.30	24071120.50	
Group Supported Employment Total:						3317400.58
Group Supported Employment - 15 minutes	15 minutes	449	2353.00	3.14	3317400.58	
Individualized Home Supports Total:						14457824.64
Individualized Home Supports - 15 minutes	15 minutes	269	6944.00	7.74	14457824.64	
				GRAND TOTAL:		1022423270.67
				Total Estimated Unduplicated Participants:		8970
				Factor D (Divide total by number of participants):		113982.53
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live-In Caregiver Total:						**2153205.12**
Live-In Caregiver - per diem	per diem	269	352.00	22.74	**2153205.12**	
Residential Habilitation Total:						**903175380.54**
Residential Habilitation - per diem	per diem	8163	333.00	332.26	**903175380.54**	
Respite Total:						**1125732.72**
Respite - 15 minutes	15 minutes	269	401.00	4.20	**453049.80**	
Respite - per diem	per diem	269	12.00	208.39	**672682.92**	
Day Habilitation Supplement Total:						**13194217.20**
Day Habilitation Supplement - 15 minutes	15 minutes	1256	3561.00	2.95	**13194217.20**	
24-Hour Self Directed Home Sharing Support Total:						**8019197.12**
24-Hour Self Directed Home Sharing Support -Level 1 - per diem	per diem	12	352.00	38.49	**162581.76**	
24-Hour Self Directed Home Sharing Support -Level 2 - per diem	per diem	43	352.00	54.29	**821733.44**	
24-Hour Self Directed Home Sharing Support -Level 3 - per diem	per diem	214	352.00	93.39	**7034881.92**	
Adult Companion Total:						**910893.41**
Adult Companion - 15 minutes	15 minutes	179	973.00	5.23	**910893.41**	
Assistive Technology Total:						**215200.00**
Assistive Technology - item	item	269	1.00	800.00	**215200.00**	
Behavioral Supports and Consultation Total:						**1937646.03**
Behavioral Supports and Conusultation - 15 minutes	15 minutes	449	201.00	21.47	**1937646.03**	
Chore Total:						**109771.20**
Chore - 15 minutes	15 minutes	90	168.00	7.26	**109771.20**	
Community Based Day Supports Total:						**19558833.80**
Community Based Day Supports - 15 minutes	15 minutes	1166	3901.00	4.30	**19558833.80**	
Family Training Total:						**406017.84**
			GRAND TOTAL:			**1022423270.67**
			Total Estimated Unduplicated Participants:			**8970**
			Factor D (Divide total by number of participants):			**113982.53**
			Average Length of Stay on the Waiver:			352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Training - 15 minutes	15 minutes	269	228.00	6.62	406017.84	
Home Modifications and Adaptations Total:						484200.00
Home Modifications and Adaptations - item	item	269	1.00	1800.00	484200.00	
Individual Goods and Services Total:						269000.00
Individual Goods and Services - item	item	269	1.00	1000.00	269000.00	
Individual Supported Employment Total:						10093525.60
Individual Supported Employment - 15 minutes	15 minutes	538	3026.00	6.20	10093525.60	
Individualized Day Supports Total:						4266140.94
Individualized Day Supports - 15 minutes	15 minutes	269	2049.00	7.74	4266140.94	
Occupational Therapy Total:						276462.06
Occupational Therapy - visit	visit	269	14.00	73.41	276462.06	
Peer Support Total:						78747.06
Peer Support - 15 minutes	15 minutes	269	82.00	3.57	78747.06	
Physical Therapy Total:						265201.72
Physical Therapy - visit	visit	269	14.00	70.42	265201.72	
Specialized Medical Equipment and Supplies Total:						322800.00
Specialized Medical Equipment and Supplies - item	item	269	1.00	1200.00	322800.00	
Speech Therapy Total:						282977.24
Speech Therapy - visit	visit	269	14.00	75.14	282977.24	
Stabilization Total:						6057761.64
Stabilization - per diem	per diem	269	84.00	268.09	6057761.64	
Transitional Assistance Services Total:						45000.00
Transitional Assistance Services - item	item	90	1.00	500.00	45000.00	
Transportation Total:						6791013.71
Transportation - one-way trip	one-way trip	897	376.00	18.66	6293495.52	

GRAND TOTAL:	1022423270.67
Total Estimated Unduplicated Participants:	8970
Factor D (Divide total by number of participants):	113982.53
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation - mile	mile	269	455.00	0.53	64869.35	
Transportation - transit pass	transit pass	269	12.00	134.03	432648.84	
Vehicle Modification Total:						**538000.00**
Vehicle Modification - item	item	269	1.00	2000.00	538000.00	
				GRAND TOTAL:		**1022423270.67**
				Total Estimated Unduplicated Participants:		**8970**
				Factor D (Divide total by number of participants):		**113982.53**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports Total:						**25213606.37**
Center Based Day Supports - 15 minutes	15 minutes	1459	3901.00	4.43	25213606.37	
Group Supported Employment Total:						**3476416.32**
Group Supported Employment - 15 minutes	15 minutes	456	2353.00	3.24	3476416.32	
Individualized Home Supports Total:						**25268382.72**
Individualized Home Supports - 15 minutes	15 minutes	456	6944.00	7.98	25268382.72	
Live-In Caregiver Total:						**3762401.28**
Live-In Caregiver - per diem	per diem	456	352.00	23.44	3762401.28	
Residential Habilitation Total:						**884061720.00**
Residential Habilitation - per diem	per diem	7750	333.00	342.56	884061720.00	
Respite Total:						**1967425.68**
Respite - 15 minutes					791766.48	
				GRAND TOTAL:		**1036695178.64**
				Total Estimated Unduplicated Participants:		**9118**
				Factor D (Divide total by number of participants):		**113697.65**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	456	401.00	4.33		
Respite - per diem	per diem	456	12.00	214.85	**1175659.20**	
Day Habilitation Supplement Total:						**13824086.88**
Day Habilitation Supplement - 15 minutes	15 minutes	1277	3561.00	3.04	**13824086.88**	
24-Hour Self Directed Home Sharing Support Total:						**14021103.36**
24-Hour Self Directed Home Sharing Support -Level 1 - per diem	per diem	20	352.00	39.68	**279347.20**	
24-Hour Self Directed Home Sharing Support -Level 2 - per diem	per diem	73	352.00	55.97	**1438205.12**	
24-Hour Self Directed Home Sharing Support -Level 3 - per diem	per diem	363	352.00	96.29	**12303551.04**	
Adult Companion Total:						**954493.54**
Adult Companion - 15 minutes	15 minutes	182	973.00	5.39	**954493.54**	
Assistive Technology Total:						**364800.00**
Assistive Technology - item	item	456	1.00	800.00	**364800.00**	
Behavioral Supports and Consultation Total:						**2029263.84**
Behavioral Supports and Conusultation - 15 minutes	15 minutes	456	201.00	22.14	**2029263.84**	
Chore Total:						**114507.12**
Chore - 15 minutes	15 minutes	91	168.00	7.49	**114507.12**	
Community Based Day Supports Total:						**20478494.55**
Community Based Day Supports - 15 minutes	15 minutes	1185	3901.00	4.43	**20478494.55**	
Family Training Total:						**710101.44**
Family Training - 15 minutes	15 minutes	456	228.00	6.83	**710101.44**	
Home Modifications and Adaptations Total:						**820800.00**
Home Modifications and Adaptations - item	item	456	1.00	1800.00	**820800.00**	
Individual Goods and Services Total:						**456000.00**
Individual Goods and Services - item	item	456	1.00	1000.00	**456000.00**	
				GRAND TOTAL:		**1036695178.64**
				Total Estimated Unduplicated Participants:		**9118**
				Factor D (Divide total by number of participants):		**113697.65**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment Total:						**10576868.58**
Individual Supported Employment - 15 minutes	15 minutes	547	3026.00	6.39	**10576868.58**	
Individualized Day Supports Total:						**7456065.12**
Individualized Day Supports - 15 minutes	15 minutes	456	2049.00	7.98	**7456065.12**	
Occupational Therapy Total:						**483204.96**
Occupational Therapy - visit	visit	456	14.00	75.69	**483204.96**	
Peer Support Total:						**137602.56**
Peer Support - 15 minutes	15 minutes	456	82.00	3.68	**137602.56**	
Physical Therapy Total:						**463478.40**
Physical Therapy - visit	visit	456	14.00	72.60	**463478.40**	
Specialized Medical Equipment and Supplies Total:						**547200.00**
Specialized Medical Equipment and Supplies - item	item	456	1.00	1200.00	**547200.00**	
Speech Therapy Total:						**494568.48**
Speech Therapy - visit	visit	456	14.00	77.47	**494568.48**	
Stabilization Total:						**10587225.60**
Stabilization - per diem	per diem	456	84.00	276.40	**10587225.60**	
Transitional Assistance Services Total:						**45500.00**
Transitional Assistance Services - item	item	91	1.00	500.00	**45500.00**	
Transportation Total:						**7467861.84**
Transportation - one-way trip	one-way trip	912	376.00	19.24	**6597626.88**	
Transportation - mile	mile	456	455.00	0.55	**114114.00**	
Transportation - transit pass	transit pass	456	12.00	138.18	**756120.96**	
Vehicle Modification Total:						**912000.00**
Vehicle Modification - item	item	456	1.00	2000.00	**912000.00**	

GRAND TOTAL:	**1036695178.64**
Total Estimated Unduplicated Participants:	**9118**
Factor D (Divide total by number of participants):	**113697.65**
Average Length of Stay on the Waiver:	352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports Total:						**26295665.75**
Center Based Day Supports - 15 minutes	15 minutes	1475	3901.00	4.57	**26295665.75**	
Group Supported Employment Total:						**3623008.22**
Group Supported Employment - 15 minutes	15 minutes	461	2353.00	3.34	**3623008.22**	
Individualized Home Supports Total:						**26345744.32**
Individualized Home Supports - 15 minutes	15 minutes	461	6944.00	8.23	**26345744.32**	
Live-In Caregiver Total:						**3922114.24**
Live-In Caregiver - per diem	per diem	461	352.00	24.17	**3922114.24**	
Residential Habilitation Total:						**921466044.90**
Residential Habilitation - per diem	per diem	7835	333.00	353.18	**921466044.90**	
Respite Total:						**2049873.38**
Respite - 15 minutes	15 minutes	461	401.00	4.46	**824480.06**	
Respite - per diem	per diem	461	12.00	221.51	**1225393.32**	
Day Habilitation Supplement Total:						**14389395.63**
Day Habilitation Supplement - 15 minutes	15 minutes	1291	3561.00	3.13	**14389395.63**	
24-Hour Self Directed Home Sharing Support Total:						**14615332.16**
24-Hour Self Directed Home Sharing Support -Level 1 - per diem	per diem	20	352.00	40.91	**288006.40**	
24-Hour Self Directed Home Sharing Support -Level 2 - per diem	per diem	74	352.00	57.71	**1503230.08**	
					12824095.68	
				GRAND TOTAL:		**1080483387.59**
				Total Estimated Unduplicated Participants:		**9218**
				Factor D (Divide total by number of participants):		**117214.51**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
24-Hour Self Directed Home Sharing Support -Level 3 - per diem	per diem	367	352.00	99.27		
Adult Companion Total:						**995417.92**
Adult Companion - 15 minutes	15 minutes	184	973.00	5.56	**995417.92**	
Assistive Technology Total:						**368800.00**
Assistive Technology - item	item	461	1.00	800.00	**368800.00**	
Behavioral Supports and Consultation Total:						**2115450.63**
Behavioral Supports and Conusultation - 15 minutes	15 minutes	461	201.00	22.83	**2115450.63**	
Chore Total:						**119320.32**
Chore - 15 minutes	15 minutes	92	168.00	7.72	**119320.32**	
Community Based Day Supports Total:						**21357428.86**
Community Based Day Supports - 15 minutes	15 minutes	1198	3901.00	4.57	**21357428.86**	
Family Training Total:						**739960.32**
Family Training - 15 minutes	15 minutes	461	228.00	7.04	**739960.32**	
Home Modifications and Adaptations Total:						**829800.00**
Home Modifications and Adaptations - item	item	461	1.00	1800.00	**829800.00**	
Individual Goods and Services Total:						**461000.00**
Individual Goods and Services - item	item	461	1.00	1000.00	**461000.00**	
Individual Supported Employment Total:						**11027561.02**
Individual Supported Employment - 15 minutes	15 minutes	553	3026.00	6.59	**11027561.02**	
Individualized Day Supports Total:						**7773967.47**
Individualized Day Supports - 15 minutes	15 minutes	461	2049.00	8.23	**7773967.47**	
Occupational Therapy Total:						**503670.16**
Occupational Therapy - visit	visit	461	14.00	78.04	**503670.16**	
Peer Support Total:						**143269.58**
Peer Support - 15 minutes	15 minutes	461	82.00	3.79	**143269.58**	
				GRAND TOTAL:		**1080483387.59**
				Total Estimated Unduplicated Participants:		**9218**
				Factor D (Divide total by number of participants):		**117214.51**
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:						**483081.90**
Physical Therapy - visit	visit	461	14.00	74.85	**483081.90**	
Specialized Medical Equipment and Supplies Total:						**553200.00**
Specialized Medical Equipment and Supplies - item	item	461	1.00	1200.00	**553200.00**	
Speech Therapy Total:						**515480.98**
Speech Therapy - visit	visit	461	14.00	79.87	**515480.98**	
Stabilization Total:						**11035178.28**
Stabilization - per diem	per diem	461	84.00	284.97	**11035178.28**	
Transitional Assistance Services Total:						**46000.00**
Transitional Assistance Services - item	item	92	1.00	500.00	**46000.00**	
Transportation Total:						**7785621.55**
Transportation - one-way trip	one-way trip	922	376.00	19.84	**6877972.48**	
Transportation - mile	mile	461	455.00	0.57	**119560.35**	
Transportation - transit pass	transit pass	461	12.00	142.46	**788088.72**	
Vehicle Modification Total:						**922000.00**
Vehicle Modification - item	item	461	1.00	2000.00	**922000.00**	
				GRAND TOTAL:		**1080483387.59**
				Total Estimated Unduplicated Participants:		**9218**
				Factor D (Divide total by number of participants):		**117214.51**
				Average Length of Stay on the Waiver:		352

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Center Based Day Supports Total:						**27101222.25**
Center Based Day Supports - 15 minutes	15 minutes	1475	3901.00	4.71	**27101222.25**	
Group Supported Employment Total:						**3731481.52**
Group Supported Employment - 15 minutes	15 minutes	461	2353.00	3.44	**3731481.52**	
Individualized Home Supports Total:						**27146040.32**
Individualized Home Supports - 15 minutes	15 minutes	461	6944.00	8.48	**27146040.32**	
Live-In Caregiver Total:						**4040572.80**
Live-In Caregiver - per diem	per diem	461	352.00	24.90	**4040572.80**	
Residential Habilitation Total:						**949122027.90**
Residential Habilitation - per diem	per diem	7835	333.00	363.78	**949122027.90**	
Respite Total:						**2110693.11**
Respite - 15 minutes	15 minutes	461	401.00	4.59	**848511.99**	
Respite - per diem	per diem	461	12.00	228.16	**1262181.12**	
Day Habilitation Supplement Total:						**14803148.22**
Day Habilitation Supplement - 15 minutes	15 minutes	1291	3561.00	3.22	**14803148.22**	
24-Hour Self Directed Home Sharing Support Total:						**15054022.72**
24-Hour Self Directed Home Sharing Support -Level 1 - per diem	per diem	20	352.00	42.14	**296665.60**	
24-Hour Self Directed Home Sharing Support -Level 2 - per diem	per diem	74	352.00	59.44	**1548293.12**	
24-Hour Self Directed Home Sharing Support -Level 3 - per diem	per diem	367	352.00	102.25	**13209064.00**	
Adult Companion Total:						**1025853.36**
Adult Companion - 15 minutes	15 minutes	184	973.00	5.73	**1025853.36**	
Assistive Technology Total:						**368800.00**
Assistive Technology - item	item	461	1.00	800.00	**368800.00**	
Behavioral Supports and Consultation Total:						**2178460.11**

GRAND TOTAL:	**1112845770.70**
Total Estimated Unduplicated Participants:	**9218**
Factor D (Divide total by number of participants):	**120725.30**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Supports and Conusultation - 15 minutes	15 minutes	461	201.00	23.51	**2178460.11**	
Chore Total:						**122875.20**
Chore - 15 minutes	15 minutes	92	168.00	7.95	**122875.20**	
Community Based Day Supports Total:						**22011704.58**
Community Based Day Supports - 15 minutes	15 minutes	1198	3901.00	4.71	**22011704.58**	
Family Training Total:						**762033.00**
Family Training - 15 minutes	15 minutes	461	228.00	7.25	**762033.00**	
Home Modifications and Adaptations Total:						**829800.00**
Home Modifications and Adaptations - item	item	461	1.00	1800.00	**829800.00**	
Individual Goods and Services Total:						**461000.00**
Individual Goods and Services - item	item	461	1.00	1000.00	**461000.00**	
Individual Supported Employment Total:						**11362236.62**
Individual Supported Employment - 15 minutes	15 minutes	553	3026.00	6.79	**11362236.62**	
Individualized Day Supports Total:						**8010114.72**
Individualized Day Supports - 15 minutes	15 minutes	461	2049.00	8.48	**8010114.72**	
Occupational Therapy Total:						**518772.52**
Occupational Therapy - visit	visit	461	14.00	80.38	**518772.52**	
Peer Support Total:						**147427.80**
Peer Support - 15 minutes	15 minutes	461	82.00	3.90	**147427.80**	
Physical Therapy Total:						**497603.40**
Physical Therapy - visit	visit	461	14.00	77.10	**497603.40**	
Specialized Medical Equipment and Supplies Total:						**553200.00**
Specialized Medical Equipment and Supplies - item	item	461	1.00	1200.00	**553200.00**	
Speech Therapy Total:						**530970.58**
Speech Therapy - visit					**530970.58**	

GRAND TOTAL:	**1112845770.70**
Total Estimated Unduplicated Participants:	**9218**
Factor D (Divide total by number of participants):	**120725.30**
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	visit	461	14.00	82.27		
Stabilization Total:						**11366268.48**
Stabilization - per diem	per diem	461	84.00	293.52	**11366268.48**	
Transitional Assistance Services Total:						**46000.00**
Transitional Assistance Services - item	item	92	1.00	500.00	**46000.00**	
Transportation Total:						**8021441.49**
Transportation - one-way trip	one-way trip	922	376.00	20.44	**7085975.68**	
Transportation - mile	mile	461	455.00	0.59	**123755.45**	
Transportation - transit pass	transit pass	461	12.00	146.73	**811710.36**	
Vehicle Modification Total:						**922000.00**
Vehicle Modification - item	item	461	1.00	2000.00	**922000.00**	

GRAND TOTAL:	**1112845770.70**
Total Estimated Unduplicated Participants:	**9218**
Factor D (Divide total by number of participants):	**120725.30**
Average Length of Stay on the Waiver:	352